STATE OF MONTANA
and
MONTANA UNIVERSITY SYSTEMS

ANALYSIS AND EVALUATION OF CLAIMS PROCESSING AND PAYMENT PROCEDURES

March 1, 1996 Through December 31, 1997

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena, MT 59620-1705

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and
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March 1, 1996 Through December 31, 1997

Submitted By

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November 1998

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the special purpose audit of the Montana Employee Benefit Plan administered by the Department of Administration, and the Montana University System Benefit Plan administered by the Office of the Commissioner of Higher Education for the period starting March 1, 1996, and ending December 31, 1997.

The audit was conducted by the Segal Company under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's and university's written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

Scott A. Seacat
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98C-07A

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TABLE OF CONTENTS

SECTION I - SUMMARY

The State of Montana and the Montana University Systems provide self-insured medical and dental benefits for active employees, retired individuals and eligible dependents under the terms of their respective Plans. Blue Cross Blue Shield of Montana (BCBSMT) provides claims administration services only under its contracts with the State and University. Vocational Resources Incorporated (VRI), a Montana based managed care organization, performs precertification of elective hospital admissions, concurrent and retrospective review as well as individual case management for the State. Utilization review services for the University are contracted through Managed Care Montana.

Montana State Law (Section 2-18-816) requires that the State employee group benefit plan be audited every two years. The audit must cover the two-year period since the last audit and be conducted by or at the direction of the Legislative Auditor. The Segal Company's initial review for the State covered the two-year period March 1, 1992 through February 28, 1994. Our second audit project, encompassing the two-year period of March 1, 1994 through February 29, 1996, included a review of case management services provided by VRI.

As requested by the Legislative Auditor, our current review covers the period March 1, 1996 through December 31, 1997 for the State and the University. This audit period includes a risk assessment of material claim fraud, in addition to a review of previous recommendations for BCBSMT and VRI.

Dates and Locations

Preliminary steps in coordinating this project with BCBSMT included a May 29, 1998 request for claims tape data, review of administrative procedures and update to previous audit recommendations. Mr. Karl Kreiger, Internal Auditor, was our primary BCBSMT contact assisting in coordinating all phases of this project. A letter was on sent June 4, 1998 to Ms. Carol Fox, VRI Case Management Director, requesting description of action taken on recommendations included in our 1997 audit report.

The BCBSMT onsite visit commenced on July 13, 1998 with an entrance interview and review of changes in administrative procedures since the prior audit period. Mr. Kreiger assisted with all phases of the audit including the daily review of claim audit worksheets. The BCBSMT exit interview was held on July 17, 1998.

Segal Audit Personnel

Ms. Carol Hoel and Ms. Lynda Sheldon visited BCBSMT's Helena office to discuss changes in administrative procedures, actions taken or the current status of prior report recommendations and to perform the review of sampled claims payments. Claims tests and verification of eligibility procedures were conducted by Ms. Hoel.

The follow-up review of VRI recommendations was conducted by Nancy R. Hakes, RN, MSN, a health care consultant with The Segal Company, in Phoenix, AZ. Ms. Hakes is a registered nurse with over 10 years of clinical hospital nursing experience and a Master's Degree in Nursing. She conducted the 1996 audit at The Segal Company's Phoenix office by reviewing hard copy records of VRI's savings and billings reports and case management files. The current follow-up project was completed through correspondence with Ms. Fox; a detailed analysis is presented in Section VI.

Segal's audit division is under the direction of Ms. MaryAnne Watson, Vice President and National Practice Leader for Claims Auditing Services. Ms. Watson coordinated the reviews with the State, BCBSMT and VRI; she also conducted the independent review of the auditor's report.

Audit Findings

Our evaluation included a review of 210 claims selected by stratified dollar amount from all claims processed during the period March 1, 1996 through December 31, 1997. Claims processed during the audit period amounted to $87,348,131.47 paid on behalf of eligible employees, retired individuals and their dependents. The 210 claims audited represented benefit payments of $1,723,675.63.

A form is completed by the auditor for each claim selected in the sample; this worksheet is the primary documentation on which this report is based. Due to the confidentiality of names, diagnoses, etc., claims addressed within this report are referred to as "Worksheets."

A recap of the accuracy rates achieved by BCBSMT for the twenty-two month period March 1, 1996 through December 31, 1997 is shown below. Industry standards are offered for comparison purposes. Based on this review, BCBSMT has achieved each industry standard.

Performance Measurements		
Category	**Achievement**	**Industry Standards**
Financial Dollar Value	99.46%	99%
Processing Accuracy (without payment or procedural error)	99.95%	95%
Payment Accuracy (free from payment error)	99.98%	97%
Turnaround Time (within 14 calendar days)	94.84%	90% - 95%

A summary of administrative procedures and test claims results are presented in Section III. A detailed description of payment, procedural and other claims matters is presented as Exhibit A of Section IV. Other claim matters are not factored into the above accuracy levels; however, they are identified so corrective action can be taken as necessary.

Based on our review of 210 claims audited, 94.84 percent of all claims were processed within 14 calendar days. A detailed analysis is presented as Exhibit B in Section IV.

Comments and Recommendations

The following items were identified during our onsite review. Details of each comment and/or recommendation are provided in Sections III and IV of our report.

Recommendation #1

Segal: It is BCBSMT's policy to apply only one deductible and/or coinsurance when charges for an inpatient confinement span two benefit periods. BCBSMT states this internal guideline is applied to all client plans. No error was assessed; however, we recommend BCBSMT confirm agreement to this internal policy with the State and University. (Page 11)

BCBSMT: BCBSMT's response states they will discuss this policy with the State of Montana and the Montana University System.

State: The State concurs with this recommendation and will review this policy with BCBSMT.

University: The University System concurs with this recommendation and will review this policy.

Recommendation #2

Segal: Refund requests should be issued for identified overpayments. (Page 18)

BCBSMT: BCBSMT's response indicates they will discuss the possibility of requesting refunds with the applicable group.

State: The State generally concurs with this recommendation and BCBSMT's response that they will discuss the possibility of refunds with the plans. Given the small dollar amount of overpayments identified for the State Plan, we are more concerned about safeguards against similar overpayments.

University: The University System concurs with this recommendation and will discuss the possibility of refunds with BCBSMT.

Recommendation #3

Segal: Home health care benefits for a University retiree were paid in excess of the Plan maximum. Total amount of benefits paid during the audit period is $68,657.87; additional payments made in 1998.

BCBSMT should confirm Medicare's current position for accurate coordination of benefits (COB); potential custodial services should be reviewed for eligible coverage under the Plan's definition of eligible home health care expenses. Discussions should be held with the University to determine appropriate recovery action. (Worksheet 186, Page 20)

BCBSMT: BCBSMT's response states a detailed analysis of the member's claim history, including a confirmation of Medicare's current position was conducted. BCBSMT indicates results of the review will be discussed with the University System and a decision on the appropriate action to be taken will be made.

State: N/A This recommendation was in reference to a specific University System case, although we will review any implications for the State Plan.

University: The University System concurs with this recommendation and will review the case and discuss appropriate action with BCBSMT.

Recommendation #4

Segal: Inpatient audiology services for a sick newborn were denied based on the University Plan's exclusion of "hearing aids, batteries and related supplies." We recommend BCBSMT implement a system edit to suspend audiology charges on patients under age two for medical review and/or investigation prior to denial. (Worksheet 188, Page 19)

BCBSMT: BCBSMT's response states the claim is being adjusted to allow the audiology charge.

State: The State generally concurs with the concept of assuring exclusions are applied appropriately. We will review the details of this situation with BCBSMT to determine if the recommended edit is the best way to accomplish that.

University: The University System concurs with this recommendation and will discuss procedure changes with BCBSMT.

Recommendation #5

Segal: Two patient files exceeded the global allowance contracted through BCBS's national transplant network. BCBSMT should implement a system accumulator or edit that will suspend all related claims under

the transplant network global allowance for verification of the benefit payment. (Worksheets 203 and 210, Page 19)

BCBSMT: BCBSMT uses a system edit to identify claims that may be related to a transplant. The items identified by the auditors were allowed to process in error by an edit clerk. Overpayments of $32.60 and $301.54 were made above the global transplant allowances of $115,000 and $103,000 for each respective patient.

State: BCBSMT's response indicates that this system accumulator/edit is in place, and that the problem was clerk error which appears to be below industry standards.

University: While the University System concurs, it appears that BCBSMT has the recommended edit in place.

Recommendation #6

Segal: BCBSMT should advise the Legislative Auditor for the State of Montana and designated representatives for Montana University Systems of any change in procedures resulting from this review as well as resolution of the payment errors addressed in this report.

BCBSMT: BCBSMT concurs with this recommendation.

State: The State concurs with this recommendation.

University: The University System concurs.

BCBSMT was presented with a draft report for their review and comment. Their response is presented as Section V.

* * * * * *

This report would be incomplete without recognition of the assistance and cooperation extended to us by the personnel of BCBSMT in preparing for this project and during the onsite phase of our work.

SECTION II - BCBSMT PRIOR AUDIT RECOMMENDATIONS

Our report on the previous audit period of March 1, 1994 through February 29, 1996 was issued in October 1996. Following is an abstract of major recommendations including the State Department of Administration's response and resolution or current status as provided by BCBSMT.

Review of Service Team Efficiency

Segal: BCBSMT's internal audit department is in the process of preparing for their initial audit following establishment of Service Teams. We encourage BCBSMT to share their findings with the State.

BCBSMT: Blue Cross and Blue Shield of Montana will provide a summary report of their audit findings to the State of Montana.

State: The State concurs with this recommendation.

Resolution: BCBSMT completed an internal control review of the Beneficiary Services Department (BSD) Service Teams in 1997. The scope of this audit included a review of BCBSMT internal controls pertaining to front-end manual data entry of claims, claims edits and adjustments for the BSD teams. The audit was recently finalized and a summary is currently being prepared. This summary will be forwarded to the State for review.

Subrogation/Third Party Liability

Segal: The State and BCBSMT should revisit their October 12, 1995 discussion to ensure that all subrogation claims activity is tracked and reported on a regular basis. The purpose of these reports is two-fold: 1) to provide accurate record of monies recovered on behalf of the State, and 2) to advise the State of possible cases that may warrant pursuit of recovery. We recommend the State implement the 6-month trial basis proposed in their response to our prior report.

BCBSMT: Blue Cross and Blue Shield of Montana concurs with this recommendation. A monthly report is being developed to provide data on savings and recoveries by subscriber. This report will be available by fourth quarter of 1996.

State: The State concurs with this recommendation. A report will be generated for BCBSMT indicating the monies recovered on behalf of the State of Montana.

Segal: In addition to implementing the reports on savings and recoveries, Segal recommends that BCBSMT provide the State with information on cases that may warrant pursuit of recovery by the State.

Resolution: BCBSMT's other party liability team provides the State with a monthly report showing all savings and recovery for worker's compensation, third party or subrogation cases. In all cases where there is not 100 percent recovery, the file is forwarded to Vivian Hammill with the State for her determination regarding settlement.

Emergency Room Expenses

Segal: System edits for covered emergency room charges, based solely on the hospital's primary diagnosis, should provide consideration for the type of treatment rendered (*i.e.,* revenue codes for extensive laboratory and surgical expenses). Current edits resulted in the denial of a sampled claim we feel may have met BCBSMT's written definition of medical emergency had the claim been submitted to medical review.

BCBSMT: Blue Cross and Blue Shield of Montana acknowledges that on an occasional basis, claims that should be covered are denied because of the way they are submitted. The Benefits Administration Committee is in the process of evaluating the way in which the system adjudicated emergency room services. They are reviewing emergency room claims denied and adjusted due to the medical emergency classification. The Committee will then have a recommendation on how to better adjudicate these claims.

State: The State concurs with this recommendation and looks forward to BCBSMT's recommendation. Currently, when emergency room claims are denied, because of the way in which it was submitted, (*i.e.*, without a sudden and serious diagnosis code) corrections are only made for participants who appeal the denial (assuming it meets the sudden and serious criteria).

Resolution: BCBSMT continues to evaluate this issue and has recently developed a report to identify all emergency room denials. The report information will be reviewed to determine the percent of denials that are adjusted to pay after receiving an appeal and/or additional information. The results of this study should help the Company determine the magnitude of the problem and possibly identify a better method of adjudicating these claims.

Hospital Primary Diagnosis Edits

Segal: Eligible equipment and services are determined by Long Range System Planning (LRSP) system edits based on primary diagnosis codes submitted by the hospital. BCBSMT should establish a threshold (*i.e.*, $250) whereby claims can be suspended for review of additional reported diagnosis that may substantiate medical necessity.

BCBSMT: Eligible equipment and services are not determined solely by diagnosis. Many factors are considered before payment determination is made. Many cases are reviewed, as in the case of the air fluidized bed.

State: In light of BCBSMT's response we will determine the factors considered and review the need for other criteria.

Segal: Based on clarification from BCBSMT regarding audit worksheet #178, page 20, we concur with the State's decision to determine appropriateness of current factors used by BCBSMT and the possible need of additional criteria for suspending certain equipment charges to determine medical necessity. Consideration should be given to financial impact to participants when an item (*e.g.*, costing $1,080.00) is provided by the hospital and subsequently determined to be ineligible and denied by BCBSMT.

Resolution: BCBSMT continues to use a number of system edits to review questionable services or supplies, and has implemented an additional edit to require review of equipment charges above $1,000. The Company believes the edits do a good job identifying items that require review, while not significantly impacting the timeliness or cost effectiveness of claims processing.

Unbundling and Upcoding Edits

Segal: Unbundling and upcoding has been identified as a provider practice to maximize benefit reimbursements. Similar to BCBSMT procedures for identification of unbundled surgical procedures, we feel additional system edits could be developed to identify certain services that should be subject to review prior to payment. For instance, all new patient codes and individual tests that should be classified as multi-channel laboratory services can be flagged by CPT code.

Standard insurance industry guidelines require automated or manual detection of unbundled and upcoded services. We have found that most major insurance carriers and third party administrators utilize

purchased or company developed software for this purpose as a routine administrative service.

BCBSMT: The lab unbundling project was reviewed periodically in the past two years and a number of ideas were researched, most of which were not cost-effective. We will be actively looking for vendors and bundling software during this next year and analyzing the cost benefit to our claims processing and group utilization experience.

State: The State concurs with this recommendation.

Resolution: BCBSMT has reviewed a number of claims bundling vendors during the past two years. Two of these vendors were invited to demonstrate their products onsite and perform an analysis of processed claims to determine any additional benefit that might be derived through implementation of their products. This analysis was accomplished by submitting a three month claim sample via tape transfer. Each vendor noted that the LSRP claims processing currently in place includes a significant number of edits and coding features already systematically providing a savings for the Company. The vendors and products reviewed were:

- HPR's CodeReview and Patterns
- GMIS' ClaimCheck and ClaimReview

These vendors did demonstrate that their products could provide additional savings to the Company. BCBSMT plans to investigate these further in 1998, with a planned cost-benefit analysis for these products. This analysis will compare the cost of the products, yearly license fees and installation costs vs. the projected savings available through the use of these products.

SECTION III - CLAIMS ADMINISTRATION

Administrative Procedures Review

As part of our audit we reviewed changes in general procedures since our October 1996 report that are specific to BCBSMT's day-to-day administration of claims processed for the State and University Plans. To assist in this portion of our review, a questionnaire was sent to BCBSMT prior to our onsite arrival. Their responses and our onsite observations allowed us to determine if effective claim control measures were in place for administration of plan benefits. Our review focused on procedures used relative to:

- *Administrative Staff* (division of duties; experience/training; and quality assurance programs)
- *Enrollment and Eligibility* (subscriber and dependent verification; receipt of employer eligibility data; timeliness of system record updates and procedures used for retroactive terminations; interface with claims processing system)
- *Provider/Participant Communications* (customer service access/response; benefit statements clarity; denial/appeal process; information requests/follow-up procedures; refund recovery)
- *Detection and Investigation Procedures* for other coverages (*i.e.*, coordination of benefits, workers' compensation, third party liability)
- *Processing Guidelines* (claims adjudication; request for additional information; referral for medical review and/or hospital audits; calculation of multiple surgical procedures)
- *Fee Schedules and Provider Files Maintenance* (usual, customary and reasonable allowances (UCR); participating provider discounts; provider records updates)
- *Claims Processing System* (duplicate payment edits; detection of fraudulent or unbundled charges; plan design changes; automated tracking of accumulators; system security)

Within each general category listed above, our audit verified that BCBSMT's procedures are within the range of generally accepted practices followed by the claims paying and insurance industry. The following comments apply to areas we believe to be of special relevance, including fraud risk assessment as requested by the State.

Administrative Staff

BCBSMT assigns accounts to member service teams who perform the core activities related to beneficiary needs (*e.g.*, customer service, adjustment processing, error resolution and member accounting) for their assigned groups. Each team has a coach while team leaders oversee more than one team to assure consistency and compliance with BCBSMT procedures.

Four accounts have been assigned to the State's Helena service team comprised of 15 employees; the University's team is responsible for 30 accounts and is comprised of 17 employees. Experienced customer service representatives are cross trained as adjustment processors. Additional cross training is provided to allow back-up for other team functions during periods of absence or peak activity.

Customer service inquiries for the State average between 650 to 750 weekly; the University averages between 400 to 600 inquiries each week.

Benefit Period Out-of-Pocket

The auditors observed a University claim (Worksheet 208) where a second deductible and coinsurance maximum were not applied to charges for an inpatient confinement spanning two benefit periods. BCBSMT provided written internal guidelines for this procedure which is applied to all client plans. No error was assessed; however, we recommend BCBSMT confirm agreement to this internal policy with the State and University.

Fraud Detection Guidelines

The claims processing system includes a number of system edits designed to identify providers for medically excessive or abusive care. These edits include suspends for multiple surgeries, unlisted procedures, multiple medical procedures and medical necessity. The system also identifies specific diagnosis codes or procedures which are inconsistent with a provider's specialty. These claims suspend for review by BCBSMT's medical review staff.

BCBSMT requires provider verification if charges appear to be altered or the total billed amount differs from itemized charges. Procedures or tests unrelated to the given diagnosis are reviewed by the medical review department for appropriateness. Suspect claims are investigated by BCBSMT's internal audit department, which also manages a toll-free anti-fraud hotline. This number is printed on every BCBSMT explanation of benefits.

Provider Maintenance

Authority to add or make changes to provider records is restricted to BCBSMT's data base maintenance staff who may receive information from providers, state boards or beneficiary services staff. Any significant changes in provider records (*i.e.*, tax identification number, licensure information, specialty changes, etc.) are verified with the appropriate agency before BCBSMT's files are updated.

BCBSMT managed care providers are subject to credentialing, including verification of their license with the appropriate state board; re-credentialing is performed every two years. Traditional providers are subject to state license verification before they are entered into BCBSMT's claims system for payment.

System Security

The corporate security team (established in 1996) is responsible for addressing security policies for BCBSMT. Currently under review is policy relating to data and systems in both the local area network (LAN) and mainframe environments. The security team will include in its review, roles and responsibilities for BCBSMT leadership and appropriate security reports for monitoring access.

The level of system access assigned to employees is determined by job requirements. Plan design details are updated by two production support staff members; UCR is the responsibility of health care services staff. Specified members of each group's service team have access to:

- employee records,
- dependent records,
- eligibility records,
- claims histories and
- benefit accumulators.

When a BCBSMT employee attempts to access the system or data that has not been defined through the mainframe security, a warning is issued and access is denied. Repeated attempts result in the suspension of the individual's system access or password. The password must be reset by support center personnel who note the reason for the suspension and report incidents to the appropriate supervisory personnel.

Claims Tests

At the request of the Legislative Auditor, certain claims tests were performed to assure proper measures are in place for accurate administration of plan benefits and fraud prevention. Under supervision of Ms. Hoel, specific claims were entered into the system's test program by BCBSMT's training personnel. Modified claims were then input at the direction of Segal's audit staff to observe all phases of claims processing and system edits. Appropriate edits or denials were noted for all tests as described below.

Duplicate Claims Test - Segal selected five previously paid claims and resubmitted them for payment. The claims were resubmitted as follows:

- one claim paid 2 months prior to date of resubmission,

- one claim paid 6 months prior to date of resubmission,
- one claim paid 10 months prior to date of resubmission,
- one claim paid 18 months prior to date of resubmission and
- one claim paid 24 months prior to date of resubmission.

The five resubmitted claims were denied by the system as duplicate charges or past the filing time limit.

Logic Claims Tests - Segal created three fictitious claims for a subscriber and submitted them for processing and payment by BCBSMT training personnel. These claims were resubmitted for payment after altering:

- the diagnosis code,
- the amount billed and
- the provider code.

The claim with altered diagnosis code was automatically denied; the claims with altered billed amount and provider code resulted in system suspension, requiring manual investigation of possible duplicate claims.

Terminated Eligibility - Tests were performed for:

- claims for an employee with terminated coverage and
- claims for a dependent with terminated coverage.

Claims on the employee with dates of service within 30 days of termination suspend for eligibility verification; charges after 30 days from the termination date are denied. Claims for services after a dependent's termination date (independent of employee's eligibility) are automatically denied by the system.

Fictitious Codes - Tests were performed for:

- claims for a fictitious provider and
- claims with a fictitious type of service code.

Claims in excess of $600 for out-of-state providers without BCBSMT identification numbers are suspended for verification and/or certification. Payments under $600 are issued to the subscriber; benefits are based on non-participating UCR for the area where services were rendered. Fictitious service types are not recognized or accepted by the claims system; the claim will be denied or suspended for additional information.

COB Logic and Usual, Customary and Reasonable Allowances - Fictitious claims were entered for:

- claims paid (or covered) by another insurer and
- claims test of usual, customary and reasonable data base.

Claims with system COB indicators were correctly denied when the charges were entered without identification of the other carrier's payment. The system accurately calculates COB with other insurance payment up to the balance or plan allowance (whichever is lower). Usual, customary and reasonable allowance is based on BCBSMT's Schedule B or 10 percent reduction of Schedule B depending on the provider's participating status.

Other System Logic - Tests claims were input for:

- a procedure not consistent with the sex of the patient and
- charges filed by both the subscriber and provider.

Gender specific procedures were entered for a male and female. The system suspended each claim for investigation of inappropriate coding. The claims paying system is unable to differentiate whether the claim has been submitted by the provider or the subscriber, however services will be denied as duplicate if submitted by both parties. BCBSMT provider contract's require benefits for services rendered by participating providers be automatically assigned which eliminates a subscriber's ability to assign benefits to themselves.

In addition to the above tests, system eligibility was verified for six State employees whose coverage had terminated in 1997 or 1998. Employee names and social security numbers were provided by the State Administration office with dates coverage was terminated according to their records. All six employee records on BCBSMT's processing system reflected accurate termination dates.

Claim Control Measures

Our review confirms the following claim control measures utilized by BCBSMT for processing and payment of claims. These are consistent with those measures we have seen followed by other insurance carriers and third party administrators.

- Dedicated service teams comprised of members from various core departments (*i.e.*, customer service, error resolution, adjustments, utilization review) have been assigned to the State and University Plans.
- System access is limited, through the use of passwords, to specific functions required by an employee's job.

- System edits alert technicians to potential pre-existing conditions, coordination of benefits and claims involving third party liability.

- Error resolution manuals provide step-by-step instruction for adjudication of claims that do not clear automated system edits.

- Automated reduction of submitted charges to appropriate pricing schedules.

- Inpatient hospital bills are reviewed by the BCBSMT utilization review department to determine if audit is warranted.

- Precertification authorizations are loaded directly into the LRSP claims process system via a nightly data transfer process from VRI.

- Provider edits identify services for review that may not be appropriate for the billing physician's specialty.

SECTION IV - CLAIMS AUDIT REVIEW

Selection of Claims

The sample of claims selected was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow us to have a quantifiable degree of confidence that the results obtained in our audit sample are a true reflection of the actual way all claims were processed during the audit period. For purposes of our audit, a claim was defined as "all charges submitted and processed for payment under one claim number."

Individual Claims Audit

Prior history and accumulators (deductibles, coinsurance and benefit maximums) were reviewed, as applicable, on each claim. In addition to verifying the amount paid, claims audited were thoroughly reviewed to determine that:

- Claims were paid in strict accordance with the provisions of each Plan.
- Amounts paid were within the designated member and non-member reasonable and customary allowances and/or preferred provider network fees for the area where treatment was rendered, taking into consideration the severity of the condition for which treatment was rendered. The scope of this audit did not include a review for medical necessity, but did consider if reviews were obtained when appropriate.
- Claims were paid only on behalf of eligible individuals as shown on the system's eligibility records.
- Claim forms, as applicable, were adequately completed with all data necessary to properly process the claim.
- Appropriate documentation (provider bills, surgical reports, etc.) was on file for claims paid.
- Benefits were paid under the proper benefit classification, diagnostic and procedure codes.
- Benefit maximums, deductibles and coinsurance levels were properly applied.
- Arithmetic calculations were correct.

- Coordination of benefits, pre-existing and subrogation provisions were enforced, where applicable.

- Duplicate payments were properly denied.

- Payments were made to the proper party, (*i.e.*, the provider of service if benefits were assigned; claimant if benefits were not assigned).

- Turnaround time for processing and payment of claims was within industry standards.

Processing Accuracy

Of the 210 claims selected for audit, 208 were processed without error. There was one overpayment of $3,870.76 and one procedural error.

The claims sampled were chosen using a stratified selection technique in order to more accurately estimate the overall processing accuracy for all claims transactions finalized during the audit period. In this process, the respective strata error rate is used to project the total errors for each strata. The total projected errors are then used to calculate the claims payment accuracy levels. The total benefit dollars paid for all claims during the audit period March 1, 1996 through December 31, 1997 was $87,348,131.47.

The following chart provides a comparison of accuracy performance during the current audit period to industry standards. Based on this review, BCBSMT has achieved each industry standard.

Performance Measurements		
Category	**Achievement**	**Industry Standards**
Financial Dollar Value	99.46%	99%
Processing Accuracy (without payment or procedural error)	99.95%	95%
Payment Accuracy (free from payment error)	99.98%	97%
Turnaround Time (within 14 calendar days)	94.84%	90% - 95%

Summary of Errors

Processing errors are classified as "payment" and "procedural"; procedural errors do not involve a variance in payment. The following chart summarizes the type of payment errors, procedural

errors and other claim matters identified during this audit period; however, claims containing multiple errors were counted as one error in determining the accuracy levels achieved in this report.

Summary of Errors			
Category	**Payment**	**Procedural**	**Other Claim Matters**
Benefit maximum not applied	1	-	1
Investigation procedures	-	2	-
Coordination of benefits	-	1	-
Global transplant allowance exceeded	-	-	2
Total	1	3	3

A detailed listing, Exhibit A, of errors identified by audit worksheet number is included at the end of this section. Other claim matters are included so corrective action can be taken as necessary. All questions and comments were reviewed with BCBSMT. We recommend refund requests be issued for the identified overpayments.

Turnaround Time

Turnaround time is calculated from the date a claim is received to the date the claim is processed by payment or denial. Claims which require additional information are calculated using the longest interval between the received date and date the claim is pended or the date a response is received and date the claim is processed by payment or denial. This analysis includes routine delays due to internal review for medical necessity, audit, etc. and excludes delays realized for draft issuance.

As noted in our analysis of accuracy levels, the process of stratification requires an adjustment in our audit observations. This is also true for the analysis of turnaround time. Accordingly, our analysis weights claims by strata, giving due consideration to the processing complexity for claims that are similarly grouped (*e.g.*, small dollar claims require less time to process than large dollar claims subject to internal reviews).

At the State's request, three calculations for turnaround time have been provided:

- Mean - 16 calendar days
  The date midway between the earliest and latest values in the date range;

- Mode - 1 calendar day
  The number of days within the date range which indicates the greatest number of claims processed; and

- Median - 1 calendar day
  The specific date within the date range at which 50 percent of the claims were processed prior and 50 percent processed after that specified date.

Based on our extrapolated analysis of 210 claims, 94.84 percent of all claims were processed within 14 calendar days. This meets industry standards which indicate 90 percent to 95 percent of all claims should be processed within 14 calendar days of receipt.

A detailed analysis of the turnaround time observed on the claims audited is included as Exhibit B at the end of this section.

Exhibit A — Error Listing

Error Listing		
Worksheet #	**Over Payments**	**Explanation**
186 University	$3,870.76	Home health care hours paid in excess of plan allowance. **Additional file overpayment may exist** following investigation of Medicare's current benefit status and verification expenses are medically necessary and not custodial in nature. During the audit period $61,571.11 in billed charges were considered; additional benefits were paid for 1998 services dates.
188 University	N/A	Inpatient audiology services for a sick newborn were denied without investigation based on the University Plan's exclusion of "hearing aids, batteries and related supplies."
203 University	Other Claim Matter (not included in error rates)	**$301.54 file overpayment;** benefits for a University participant were paid in excess of the global allowance contracted through BCBS's national transplant network.
210 State	Other Claim Matter (not included in error rates)	**$32.60 file overpayment**; benefits for a State participant were paid in excess of the global allowance contracted through BCBS's national transplant network.
Total	$3,870.76	Overpayment (1) Procedural Error (1) Other Claim Matters (3)

Exhibit B — Turnaround Time

Turnaround Time			
Calendar Days	**Number of Claims**	**Individual Percent**	**Cumulative Percent***
0	31	19.59%	19.59%
1	58	31.83%	51.43%
2	23	11.77%	63.20%
3	15	8.10%	71.30%
4	10	5.12%	76.42%
5	6	2.58%	79.00%
6	7	2.78%	81.78%
7	4	1.33%	83.11%
8	12	4.12%	87.23%
9	1	0.12%	87.35%
10	3	0.65%	88.00%
11	3	1.53%	89.53%
12	2	1.43%	90.96%
13	5	1.66%	92.62%
14	**4**	**2.22%**	**94.84%**
15	1	0.22%	95.06%
16	1	0.12%	95.18%
17	4	1.26%	96.43%
18	2	0.50%	96.94%
20	2	0.05%	96.99%
21	3	0.33%	97.32%
23	1	0.64%	97.96%
24	2	0.85%	98.81%
25	1	0.12%	98.93%
26	1	0.50%	99.42%
28	1	0.00%	99.42%
34	1	0.01%	99.43%
36	1	0.50%	99.93%
39	1	0.02%	99.95%
48	1	0.02%	99.98%
55	1	0.02%	100.00%
76	1	0.00%	100.00%
89	1	0.00%	100.00%
	210	100.00%*	* May not add due to rounding

SECTION V - BCBSMT RESPONSE TO DRAFT REPORT

Blue Cross Blue Shield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406)444-8200

Customer Information Line:
1-800-447-7828

August 14, 1998

AUG 2 0 1998

CAROL HOEL
THE SEGAL COMPANY
5080 N 40TH ST STE 400
PHOENIX AZ 85018

RE : State of Montana/Montana University System Administrative Review and Claims Audit

Dear Carol:

This letter will acknowledge receipt of the draft report for the State of Montana/Montana University System audit recently completed for the audit period March 1, 1996 through December 31, 1997.

The remainder of this letter includes the response of Blue Cross Blue Shield of Montana (BCBSMT) to the Comments and Recommendations listed on page three of the report. The Comments or Recommendations have been repeated, followed by the reply from the Company.

Page 3 "It is the policy of BCBSMT to apply only one deductible and/or coinsurance when charges for an inpatient confinement span two benefit periods. BCBSMT states this internal guideline is applied to all client plans. No error was assessed; however, we recommend BCBSMT confirm agreement to this internal policy with the State and University (Page 9)."

Comment: *BCBSMT will discuss this policy with the State of Montana and Montana University System.*

Page 3 "A refund request should be issued for identified overpayments (Page 16)."

Comment: *BCBSMT will discuss the possibility of requesting refunds with the applicable group on a case by case basis.*

Page 3 "Home health care benefits for a University retiree were paid in excess of the Plan maximum. Total amount of benefits paid during the audit period is $68,657.87; additional payments made in 1998.

BCBSMT should confirm Medicare's current position for accurate coordination of benefits (COB); potential custodial services should be reviewed for eligible coverage under the Plan's definition of eligible home health care expenses. Discussions should be held with the University to determine appropriate recovery action. (Worksheet 186, Page 18)"

Comment: *BCBSMT has conducted a detailed analysis of this member's claim history, including a confirmation of Medicare's current position. The findings of this review will be shared with the University System within the next week. A decision on the appropriate action to be taken will be made with the University System after they have been briefed on the history of this case.*

Page 3 "Inpatient audiology services for a sick newborn were denied based on the University Plan's exclusion of 'hearing aids, batteries, and related supplies'." We recommend BCBSMT implement a system edit to suspend audiology charges on patients under age two for medical review and/or investigation prior to denial. (Worksheet 188, Page 18)."

Comment: *BCBSMT is currently adjusting this claim to allow the denied audiology charge. System coding is also being reviewed, in an attempt to determine why this service was denied without further review and how this type of error can be prevented in the future. BCBSMT will take into account the auditor's recommendation for an audiology system edit for patients under the age of two when a final decision is made on how to appropriately administer benefits for this type of service.*

Page 3 "Two patient files exceeded the global allowance contracted through BCBS's national transplant network. BCBSMT should implement a system accumulator or edit that will suspend all related claims under the transplant network global allowance for verification of the benefit payment. (Worksheets 203 and 210, Page 18)."

Comment: *BCBSMT uses a system edit to identify claims that may be related to a transplant. The items identified by the auditors were allowed to process in error by an edit clerk. Overpayments of $32.60 and $301.54 were made above the global transplant allowances of $115,000 and $103,000 for each respective patient.*

Page 3 "BCBSMT should advise the Legislative Auditor for the State of Montana and designated representatives for Montana University Systems of any change in procedures resulting from this review as well as resolution of the payment errors addressed in this report."

Comment: *BCBSMT concurs with this recommendation.*

Thank you for the opportunity to comment on this audit report. If you have any questions or comments, please don't hesitate to contact me at (406) 444-8211.

Sincerely,

Karl Krieger
Internal Auditor

SEGALRE2.DOC

SECTION VI - VRI PRIOR AUDIT RECOMMENDATIONS

Background

In 1996, The Segal Company was requested by the State of Montana to perform a review of the utilization management organization responsible for case management for plan participants of the self-insured Montana Medical Plan. The utilization management firm, Vocational Resources Inc. (VRI), is a wholly owned subsidiary of Blue Cross and Blue Shield of Montana. Their primary office is located in Billings, Montana.

This 1996 case management services audit was completed in the fall of 1996 and a report was submitted to the State of Montana indicating such information as:

- The services under contract to VRI as well as VRI's compliance with contract requirements;
- An overview of VRI's organization including staffing capabilities;
- Reporting capabilities including an assessment of savings assumptions;
- A random selection of 25 individual patient cases investigating documentation, process, effectiveness and reported saving assumptions of case management services.

The audit also contained a section on recommendations for VRI.

During 1997, The Segal Company was contacted by a representative of VRI (C. Hecker) requesting assistance in their review of new savings reports and an assessment of current documentation of case management efforts. At two different times in 1997, The Segal Company was sent individual case records and requested to provide comments to VRI. Comments were sent to VRI.

In the spring of 1998, The Segal Company was requested by the State of Montana to perform a follow-up assessment regarding VRI's compliance with The Segal Company's recommendations from the 1996 audit. The following information outlines The Segal Company's assessment of VRI's compliance with those 1996 recommendations.

Methodology

The Segal Company contacted VRI in late May of 1998 to notify them that we would be conducting a follow-up review of the 1996 audit recommendations. The director of case management who had been involved in the 1996 and 1997 case reviews was no longer an employee of VRI. A new director, Ms. Carol Fox, was contacted. In a letter to VRI dated June 4, 1998, The Segal Company requested that VRI review the recommendations in the 1996 case management audit and provide a

written response to each recommendation, with appropriate documentation. VRI was asked to send a sample of records (where appropriate) demonstrating that the recommendations had been incorporated into their case management review function. A total of three records per recommendation was requested, having VRI highlight/underline in the notes where they believe they demonstrate evidence of implementation of the recommendation. VRI was requested to send this information to The Segal Company by July 8, 1998 and they furnished it in a timely manner. The Segal Company received a three-ring binder containing VRI's response to each of the 14 recommendations from the 1996 audit as well as sample records.

Findings Of The 1998 Follow-up Of Case Management Recommendations

The following outlines each of the 14 recommendations made by The Segal Company during their 1996 audit of VRI's case management services and VRI's response. See also Exhibit 1 for a copy of VRI's actual response document.

Recommendation #1

Shift the emphasis of case management efforts from negotiating discounts on individual cases to redirection of patients toward providers where a previously negotiated discount arrangement is in place. With the clout of your review organization (VRI) or that of Blue Cross and Blue Shield of Montana, consider developing a comprehensive network of ancillary providers *(e.g.*, home health, home infusion therapy, hospice, skilled nursing facilities, physical therapy, etc.) for the patients of the State of Montana and for your own use in case management.

> ***Response:*** VRI indicates that they continue to develop negotiated discount arrangements with various types of vendors. They have two key types of discount arrangements: those available through the Blue Cross and Blue Shield Association, and those available through their own pricing agreements or arranged through the Lantis Corporation.
>
> Exhibit 2 is a copy of the document provided by VRI to demonstrate the types of vendors by city and where there is a pre-negotiated discount arrangement.
>
> Exhibit 3 is a table prepared by The Segal Company to demonstrate the number of pre-negotiated contracted vendors compared to the number of available non-contracted vendors. Clearly, VRI case managers now have access to more vendor discount arrangements than in 1996. Additional contracting efforts are needed however, in order to assure adequate geographic coverage. Enhancing coverage will help eliminate the time case managers spend negotiating rates for health care services. In those areas where no discounts have yet been negotiated, it would be helpful for all the case managers to have access to "goal" prices for various common case management type services. Then the nurses can determine, on their case by case fee negotiations, when they have reached a reasonable discount. Additionally, this will allow for greater consistency between nurses on their fee negotiation efforts.

Recommendation #2

Consider shifting the emphasis of case management efforts to determining whether the physician or vendor is proposing the **most cost-effective/medically necessary** treatment plan and intervene to change a proposed plan to a more creative design and fiscally sound plan, where appropriate. Measure the difference between the plan the health team originally proposed and the new creative one VRI developed.

For example: Doctor orders home health 5 times/week for dressing changes and it is noted that the dressing changes could be done in the doctor's office daily at little or no cost. VRI's impact would be the difference between the cost for the home health visit and the fee for the office visit. There may even be no office visit fee as post-surgical physician visits are typically included in the global fee for the procedure itself; or,

Physician orders home health for wound care with no specific guidelines and it is noted that home health vendor plans to send out RNs for each visit. An alternative may be proposed which would utilize LVNs at a lesser per-visit cost with a stipulation that the home health vendor teach the patient/family how to change dressings. Savings would be the difference between the cost of RN visits and LVN visits times the number of total visits used.

> ***Response:*** VRI's response indicates that they have increased their emphasis on better documentation of alternatives when they determine the treatment plan can be improved or is not appropriate. They indicate that due to "time constraints and the lack of purpose for doing so, all the alternatives considered before implementing the plan of choice may not be recorded in documentation." While VRI indicates that several of the cases submitted demonstrate their compliance with Recommendation #2, it is noted that additional documentation is necessary to assure that an independent review of records, retrospectively, clearly demonstrates that VRI was proposing treatment plans that were more cost effective and different than those originally considered by the patient's physician.

Recommendation #3

Develop formal and comprehensive written screening guidelines specific to the kinds of situations confronting case management services (these criteria will be a little different than precert criteria for hospital admissions). Case management criteria should indicate when the review staff can unilaterally approve the use of certain types of durable medical equipment, home health, infusion therapy, home uterine monitoring, skilled services, inpatient rehabilitation, etc. Such criteria should be reviewed by the State to assure that they are in agreement as to why certain services will be authorized, as they are the payor.

> ***Response:*** VRI indicates that they now use the most recent version (May 1998) of Milliman & Robertson's Health Management Guidelines. There is no evidence this or other criteria has been approved by the State. They also indicate that the nurses have on-line access to medical policy manuals utilized by Blue Cross and Blue Shield of Montana. In some of the cases submitted, documentation was found indicating

nurses had referred to criteria; however, the specific criteria referenced was not able to be identified.

In order for an independent auditor to retrospectively review records and demonstrate compliance with screening guidelines, it is important that the case manager document exactly which element of which criteria was utilized. Often this is accomplished by numbering the criteria in such a manner as to allow the UR staff to use such numeric codes instead of narrative documentation. For example, some UR firms have taken the Milliman & Robertson Guidelines and numbered the criteria for easy reference in their documentation. (The criteria for rehabilitation may be coded as R-4b, to indicate use of rehab criteria (R), the fourth indicator (4), item "b" to approve or disapprove a particular case review). Using this or a similar process allows for prompt retrieval of the criteria chosen by staff at the time of case review or retrospective review and internal auditing to assure staff use the correct indications for approval or denial of cases.

Recommendation #4

Consider **daily** case management team meetings with UM nursing staff and appropriate physician advisors to brainstorm ideas for complex patient case situations. Step back from long or tough cases and look retrospectively at them. Where were missed opportunities, what can be done now, what are the trends (*e.g.*, repeat admissions for diabetes suggests increased individual patient education on diet and glucose monitoring, or notes seem to suggest that the family is learning a patient's care so that fewer home health visits should now be considered)?

Response: VRI indicates that daily case conferences occur to review difficult, complex cases. They collaborate with case managers, the medical director, clinical program manager and supervisor.

Recommendation #5

Develop a formal internal quality assurance program which monitors nurses application of criteria and operational protocol **and** analyzes VRI physician advisor's review decisions for creativity, accuracy and trends.

Response: VRI created an internal quality assurance program measuring aspects of their case management department operations. Their quality assurance checklist assesses the following:

- the referral source
- goals documented within one week of opening a case
- benefits checked
- treatment plan assessed
- bi-weekly contact with the case
- case manager is in control
- there is a positive outcome

- goals accomplished
- cost savings verified

VRI indicates that they perform this review quarterly and have included a copy of their internal audit results for the first two quarters of 1998 in Exhibit 4. Additional material submitted after VRI's review of the draft report indicates that they have an internal QA tool which reviews nurses's application of criteria and Physician Advisor decisions.

Recommendation #6

Refine reports to clearly demonstrate UM effectiveness. Assure that savings are valid, realistic, and are able to be verified/audited. Fee negotiation should demonstrate what the cost would have been at a pre-discount (*e.g.*, fee-for-service) level minus the discount arrangement. Demonstrate savings from altering the treatment plan to clearly reflect the plan the health team would have implemented had VRI not been involved versus the plan VRI designed that the health team would not have considered.

Response: VRI indicates that they have changed their report format for case management from a lengthy 2-4 page report to an abbreviated report for efficiency and to maintain patient confidentiality. A copy of this new report is located in Exhibit 5.

They include information about negotiations and savings in the actual case documentation and indicate the State of Montana can request a complete copy of case records or request detailed written in-depth reports for specific needs. VRI's documentation does contain notes about the fees prior to and after fee negotiation efforts.

Recommendation #7

Research the State's benefit limitations and relay these to the patient/health team before offering extra-contractual benefit options. Help the team strategize how a plan of care can be developed that works within the benefit design, not outside. Given limitations, vendors can be creative and innovative when required. Where benefit limits are too restrictive for even the cleverest of care plans, discuss with the State how the plan document can be amended so that benefits are consistently applied across the State's plan population, not extra-contractually for only certain individuals.

Response: VRI indicates that they understand that extra contractual benefits must be used sparingly and are to be approved by the State of Montana Group Leader. The records provided do demonstrate that VRI is seeking the approval of the State of Montana prior to implementing extra contractual benefits.

Recommendation #8

Take an assertive role in quickly suggesting, researching and implementing financial options for those unfortunate individuals who will have long term health care needs (*e.g.*, quads, cancer, etc.). This may include Social Security, Medicaid and Medicare benefits as well as coordination of benefits with other insurance carriers. Consider not leaving this vital task to the discharge planner at a facility as they have little incentive to move quickly to secure long term financial alternatives before existing benefits run out.

> *Response:* VRI indicates that their case managers work directly with patients to assist them in finding other financial arrangements such as Medicare, Medicaid or Social Security. VRI also indicates that they have a fully staffed 24 hour resource center with the ability to track community resources. Notes from some cases presented demonstrate that VRI has suggested the above financial options to certain patients.

Recommendation #9

When the clinical situation is appropriate, hold firm to your recommendations of non-certification for continued stay or admission. Do not allow providers to "blackmail" VRI into authorizing more inpatient days than the patient needs or demanding that if more home health care is not approved they'll be forced to readmit the patient. If the patient does not meet the medical criteria for an admission or continued stay, those services should not be authorized.

> *Response:* VRI indicates that for a hospitalization to be approved, the patient must meet nationally recognized criteria. If the criteria is not met, the case is referred to their benefits coordination team in conjunction with a physician advisor. The team reviews the impending denial for cost effective alternatives and if there are no options to hospitalization, the physician advisor will review and discuss the case with the attending physician. If criteria is still not met, the hospitalization is denied. VRI indicates that at the same time the patient is informed of the right to appeal. They also indicate that during this process, an efficient treatment plan usually emerges. VRI presented a few cases where they felt they had been able to stand firm on their original recommendation of non-certification for continued stay or an admission.

Recommendation #10

Consider tighter screening criteria for inpatient rehab use (*e.g.*, Milliman and Robertson's criteria) so that patients with cognitive deficits (confused, inability or difficulty to learn or remember) do not use expensive inpatient rehab resources without maximum benefit and are instead managed outpatient and more cost effective.

> *Response:* VRI established a rehabilitation team in 1997 to evaluate potential admissions to acute rehab units. Their team consists of nurses and doctors skilled in rehabilitation issues who review all cases for medical necessity. VRI indicates the rehab team compares inpatient rehabilitation with other options such as transitional

care units, skilled nursing facilities, outpatient rehab programs and home therapies. They also indicate that most rehab cases receive an onsite assessment to ensure valid clinical information is used. VRI presented a copy of their rehabilitation criteria which is included in Exhibit 6. VRI also presented some cases where they applied their criteria to the case situation.

Recommendation #11

Work with Blue Cross and Blue Shield to obtain a monthly "high/large claims report." The one obtained from Blue Cross for this audit listed all patients who had paid charges in excess of $100,000. If case management screening is working properly, UM should be finding every case that eventually becomes expensive. Checking monthly is a good way to assure that you have not overlooked a patient who should be case managed. Perhaps even lower the limit to all patients with paid claims over $50,000, to control the case early, not when the patient has reached $100,000.

> ***Response:*** VRI indicates they are working with Blue Cross and Blue Shield of Montana to combine efforts to cross reference claims data and case management efforts. It does not appear from their response that they have yet completely accomplished this recommendation.

Recommendation #12

On a few of the 25 cases audited, a physician advisor or the Medical Director was utilized. However, the notes do not document these physicians pursued investigation of alternative options before reaching a decision to extend confinement or approve the original request. All requests for review were determined in favor of the patient or requesting physician without further suggestions or innovative problem-solving to assist the staff nurses or conversation with the attending physician as to an alternative and perhaps more cost-effective route.

> ***Response:*** VRI indicates that their physician advisors routinely discuss the medical details of cases with the patient's attending physician. They provided some cases demonstrating documentation that VRI physician advisors are conversing with the attending physician to discuss options for continued care.

Recommendation #13

Consider reworking the bill matching/research function of case managers. The matching of a vendor's billed charges with the actual VRI authorized services could be handled by the claims department as with any other type of bill. The case managers are too expensive and valuable to use their time performing non-medically related services. When VRI authorizes a service through the case management process, a complete description of the information (*e.g.*, vendor name, frequency of visit, cost for visit duration of visits, etc.) should be written allowing copies of the crucial information to be forwarded to the vendor/provider/facility, the patient, the claims department and one for the case manager's file.

Response: VRI indicates that they have explored other options for matching the bill to the approved case management services but that some case manager review is essential for closing the audit loop to prevent misallocation of funds. They indicate that claims department clerks within the Blue Cross and Blue Shield of Montana facility do match claims with approved services and return any mismatches to VRI case managers for further attention.

Recommendation #14

Consider recommendations for improvement in contract compliance as outlined below:

C-1: VRI should produce ongoing reports (*e.g.*, quarterly) which detail the number of cases selected for screening followed by an account of the number of screened cases selected for actual case management.

Response: VRI indicates that after a three month review of cases screened during 1997, the number of cases screened remains constant. They indicate that 5 percent of screened cases are actually open to case management and that 10-15 State of Montana cases from the precertification system are screened each day. They provided additional information after review of the draft audit report that they are able to track the number of cases selected for screening versus the actual cases managed.

C-3a: No evidence of goals (short and long term) documented for each case. Articulating goals should help determine if the physician's treatment plan is realistic (*e.g.*, is the paraplegic patient really expected to walk again? If so how soon? Thus, is the type, frequency, duration and location for physical therapy appropriate?)

Response: VRI has incorporated the need to document goals into their formal quality assurance program performing self-audits to measure documentation. VRI indicates that in the first half of 1998 they achieved a 93% compliance rate for documentation of goals. Exhibit 4 demonstrates the internal audit accomplishments.

C-5b: Consider amending the contract to release VRI from responsibility for consent forms, making case management an integral part of the State's medical program, not that it is only possible if the patient/family agrees to be case managed.

Response: VRI indicates that their case management program is now voluntary and that they obtain verbal consent but do not require written consent forms.

C-5d: If approved by the State, consider limiting the use of extra-contractual benefit overrides to both picking up the patient's coinsurance responsibility and adding benefits where the plan design has a fixed limited amount (*e.g.*, home health visits, physical therapy dollars, etc.).

Response: There is no mention in the VRI response as to whether or not VRI has communicated with the State to determine their preference for waiving of the patient's coinsurance liability. VRI indicates they waive coinsurance responsibility when the family would refuse to use the benefit without this waiver due to financial hardship. They also indicate that the patient must be at risk for readmission or other costly covered benefits in order to obtain this coinsurance waiver. VRI indicates some vendors will discount at a greater level if case management pays 100 percent because the vendors prefer not to bill the patient, and this can be a "bargaining chip to obtain lower prices from vendors." VRI supplied several cases in which they have **not** waived coinsurance responsibility or offered extra-contractual benefits without the approval by the State.

C-i: Consider amending this contract wording such that VRI can stop case management services when it is apparent that although the patient's goals have not been met, no further case management impact is apparent and only case monitoring (not necessarily a cost-saving service) will be occurring.

Response: VRI indicates that there has not been any issue where they feel they have been unable to stop case management services when there is no further impact. On difficult cases they indicate the group leader is made aware of case closure when the patient requests further assistance. VRI supplied cases demonstrating they are able to stop their case management services when no further impact is apparent.

VRI's Response to Review of the Draft Report

On July 24, 1998, VRI was allowed the opportunity to review the auditor's draft report and submit additional information. Exhibit 7 includes a copy of VRI's response. On August 11, 1998, the auditor and two representatives of VRI (D. Gianchetta and P. Bogumill) conversed about the auditor's need to obtain written evidence of compliance with certain areas which has been designated as "needs improvement." On August 17, 1998, the auditor received an addendum to VRI's draft review. This is included as Exhibit 8.

In response to both of VRI's written comments on the draft report, the auditor notes the following:

- The auditor has modified the summary table and narrative description of the table.

- ***Recommendation 1***: VRI asked that the auditor indicate that this category is listed as "Evidence of Improvement." The auditor notes that some rural locations as well as the more populated locations in Montana (*e.g.*, locations with a census of 15,000 or greater such as Missoula, Helena, Great Falls, Bozeman, Butte and Billings) still do not have a fully developed network of contracted vendors for the key ancillary services of home health, home infusion therapy, medical equipment, hospice and skilled nursing facility/long term care. While improvement has been made, additional contracting efforts are needed. Redirection of the patient and physicians to a contracted

ancillary vendor is much more cost-effective than the time and costs for case managers to attempt to negotiate discounts at the time of service.

Final auditor note: No change to original draft finding is suggested.

- ***Recommendation 2***: VRI understands that in order to demonstrate compliance of this recommendation, the case notes must reflect documentation of the physicians treatment plan and whether or not VRI staff find this plan to be efficient and necessary. Where the plan is found to be unnecessary or not cost-effective, VRI should document the plan they have designed and the physician's reaction to this suggested plan. Then a measurement can be documented showing the cost savings between the original plan and the new suggested plan. VRI indicates that they are working to improve documentation.

  Final auditor's note: No change to original draft finding is suggested.

- ***Recommendation 3***: VRI submitted additional information indicating that they have taken steps to develop criteria for hospice to assist case managers. *Final auditor's note: The recommendation of "needs improvement" still remains.*

- ***Recommendation 5***: VRI submitted additional information indicating that their QA tool does screen for the nurses accurate application of criteria and a tool which re-reviews health care advisor decisions. *Final auditor's note: The original finding of "needs improvement" has been changed to "evidence of improvement."*

- ***Recommendation 14-C1***: VRI submitted additional information demonstrating that they are able to track the number of cases screened versus actually case managed. *Final auditor's note: The original finding of "needs improvement" has been changed to "evidence of improvement."*

- ***Recommendation 14-C5d***: VRI clarified their response to indicate that the sample records provided demonstrate that they are no longer offering extra-contractual benefits, waiving coinsurance responsibility or adding benefits when the plan design has fixed amounts. *Final auditor's note: The original finding of "needs improvement" has been changed to "evidence of improvement."*

Summary Of Findings

The following table summarizes the findings of the review of VRI's compliance with the 1996 Case Management audit recommendations. VRI has demonstrated evidence of improvement on 14 of the 18 recommendations or 78%. They have taken steps to comply with the remaining 4 recommendations (22%); however, additional improvement is suggested.

Note that the recommendations have not been weighted for degree of importance or priority.

Recommendation Number	Evidence of Improvement	Improved but Needs More Work	No Evidence Improvement
1		x	
2		x	
3		x	
4	x		
5	x		
6	x		
7	x		
8	x		
9	x		
10	x		
11		x	
12	x		
13	x		
14 (C-1)	x		
14 (C-3a)	x		
14 (C-5b)	x		
14 (C-5d)	x		
14 (C-i)	x		
TOTAL	14	4	0

SECTION VII - VRI RESPONSES AND EXHIBITS

Exhibit 1 — VRI's Original Response

VRI

A MANAGED CARE COMPANY

July 2, 1998

Nancy Hakes, RN, MSN
Vice President
The Segal Company
5080 North 40th St., Ste. 400
Phoenix, AZ 85018

RE: State of Montana Case Management Audit

Dear Ms. Hakes:

The audit process began with your first effort in August and September of 1996. Twenty-five cases were audited, and as a result, VRI changed many of its policies and practices.

Changes were implemented in November of 1996. Subsequently, in March, 1997, you audited eight additional State of Montana cases. In July, VRI requested that you audit eighteen cases (not just State of Montana) as part of our quality improvement process. Your audit report, dated August, 1997, was shared with the State of Montana along with our responses to the audit and the progress to date on the recommendations from the original 1996 audit. The 1997 audit showed significant improvement in VRI's Case Management processes and documentation efforts.

VRI has continued to utilize the seven point audit criteria (with some additional components) as part of our quality assurance. Every single State of Montana case closed between January 1 through June 24, 1998 was reviewed using these criteria. The overall criteria compliance ratio is 93%. Detailed results of these 55 closed cases are tabulated and appear in Attachment A, which includes a brief description of the criteria as well.

In your letter dated June 4, 1998, you requested that VRI provide a written response to the 1996 audit and provide three sample cases for specific recommendations to demonstrate that they have been incorporated into our review function. We have provided a table in Attachment B that lists the eleven recommendations and the ten sample cases that support the integration of the recommendations. The sample cases are numbered one through ten to maintain client confidentiality.

Because VRI is committed to continuous quality improvement, we persist in our efforts to enhance our Case Management Department. There is still a need for VRI to improve documentation of results and cost savings, increase on-site visits, increase physician and peer reviews, address other party liability, and identify earlier entry points for Case Management.

VRI is taking a more active role in discussing potential for changes to the benefit and plan document because of Case Management needs or interventions. An example is the

one time/lifetime obesity benefit treatment that was added to the State benefit plan. Untreated obesity increases the patient's morbidity and risk of high-cost complications, such as diabetes, sleep apnea, and degenerative joint disease of the weight-bearing extremities. Intervention should prevent costly complications.

Pulmonary rehabilitation education is currently an exclusion on the State benefit plan. VRI has been supported by both BCBS Montana and the State to provide this benefit extra-contractually. This out-of-plan education has proved beneficial in preventing acute hospital episodes, reducing emergency room treatment, and decreasing overall drug usage. Pulmonary rehab is now considered as a possible benefit change because of the large medical offsets it can afford with both education and compliance to diet, exercise and drug therapy.

I am hopeful we have provided all necessary information and you find our responses complete. Any questions should be directed to Carol Fox at 800/635-5271, ext. 8770. Her mailing address at VRI is Norwest Building, Ste. 301, 350 N. Last Chance Gulch, Helena, Montana 59601.

Sincerely,

Deslie D. Gianchetta, MBA, CRC
Executive Vice President & COO

DDG/tp
Enclosures

1. ***Shift the emphasis of Case Management efforts from negotiating discounts on individual cases to redirection of patients toward providers where a previously negotiated discount arrangement is in place.***

VRI continues to develop negotiated discount arrangements with various types of vendors. VRI's Case Management utilizes vendor arrangements that are available through the BlueCross BlueShield Association, BlueCross BlueShield of Montana (BCBS Montana), and pricing agreements that VRI has established. Some examples of such arrangements include:

- Home Infusion
- Durable Medical Equipment
- Physical Therapy Services
- Occupational Therapy Services
- Speech Therapy Services

These pricing arrangements facilitate the identification of appropriate resources with prearranged pricing throughout the state of Montana, and nationally as well. Included in this document as Attachment C is a VRI Provider List utilized by our Case Managers. The discounted prices are kept current at the Case Managers' desks and by an updated computer information rate file. These pricing arrangements are proprietary and confidential.

Pricing agreements are developed as needs arise. Currently VRI and BCBS Montana, have identified an increased need for sub-acute and skilled nursing services to allow for inpatient services to be rendered at a lower level of care. Both levels of care are a covered benefit by the State of Montana. The benefit structure allows for 70 days of services at these levels.

BCBS Montana and VRI are developing statewide pricing arrangements for these levels of care which started with an agreement for skilled level of care with Lantis Corporation. Our intent is to create demand and competition in contracting with these facilities, even though Montana requires a certificate of need for new facilities. Our strategy is working. We are seeing skilled nursing wings being built or converted in some long-term care facilities, which creates competition for the hospitals. Although hospitals were the first to respond, it is difficult to obtain good pricing from them. In addition to reducing price, increased competition also reduces the time needed to coordinate treatment plans that utilize sub-acute or skilled nursing levels of care.

For case samples that support VRI's response to this recommendation,
please refer to case numbers
(which are highlighted and labeled by question number in the margin):
1, 3, 4, 7, 8, 9, 10

2. Document vendor/physician treatment plan with VRI proposed treatment plans.

VRI has increased the emphasis on better documentation of alternatives considered whenever the identified treatment plan can be improved or is not appropriate. Nevertheless, due to time restraints and lack of purpose for doing so, all the alternatives considered before implementing the plan of choice may not be recorded in documentation. A specific example, as documented in Case #1, follows:

> *A 41-year-old woman was admitted to the hospital with serious complications of alcohol abuse. Her hospital stay was seven days and could have been much longer. While in the hospital, Case Management negotiated the room rate to a lower rate, facilitated a move to a sub-acute level of care, and then arranged for home health. Physician treatment plan was for inpatient. This was possible because Case Management did an on-site at the hospital and the sub-acute facility to determine if needs could be met with lower levels of care.*

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
1, 2, 3, 4, 5, 6, 7, 9, 10

3. Develop formal and comprehensive written screening guidelines for Case Management.

VRI utilizes the most recent version of Milliman & Robertson's Health Management Guidelines (HMG) which just became available in May of 1998. The guidelines provide a framework for highly efficient delivery of healthcare. They also provide a good resource for Case Managers to unilaterally approve/coordinate the use of certain types of home health services, skilled services, durable medical equipment, inpatient rehabilitation, and so forth. Included with this document as Attachment D is a marketing sample of the HMG guidelines.

Our Case Managers have on-line access to the Medical Policy manual utilized by BCBS Montana/State of Montana. This manual defines criteria for services, procedures, equipment, and pharmaceuticals that the benefit plan requires to be pre-authorized and/or evaluated prior to consideration for payment. Medical Policy is developed by researching recent scientific literature and considering availability of services and supplies.

4. Consider daily Case Management meetings with UM nursing staff and appropriate Physician Advisors to brainstorm ideas for complex patient cases.

Daily case conferences occur to review difficult, complex cases. We encourage collaboration between Case Managers. VRI has a Medical Director, a Clinical Program Manager (Physician Assistant), and a Supervisor (an experienced Registered Nurse and Certified Case Manager) who are all available daily for case conferences. As an illustration of this process, consider Case #2:

A 62-year-old patient had a severe head injury. The Physician Advisor spoke with the treating physician and reviewed the clinical information in detail. Together, the Case Manager and Physician Advisor determined that the patient was stable enough to be moved to sub-acute care for continued therapy so that costly inpatient rehabilitation was avoided. The Case Manager also raised the question of eligibility for social security disability benefits with the family.

5. ***Develop a formal internal quality assurance program which monitors nurses' application of criteria and operational protocol and analyzes VRI Physician Advisors' review decisions for creativity, accuracy, and trends.***

VRI has a company-wide Quality Assurance (QA) program, which includes the Case Management department. This program monitors team and individual performance to ensure compliance with program protocols and philosophy. The QA program also monitors VRI Physician Advisors' decisions and processes.

The best way to insure quality is to incorporate improvements into day-to-day Case Management activity. The following checklist, which is part of the QA process, is found on each Case Manager's computer console:

	*Referral Source*	
	*Goals documented in 1 week*	
	*Benefits ✓'d*	
	Treatment plan assessed	
	*Bi-weekly contact*	
	*CM in control??*	
	*Positive Outcome*	
	*Goal Accomplished*	
	*Cost Savings Verified*	

QA reviews are done at least quarterly on 90% of the closed cases for the Case Management department. In addition, VRI is developing a mechanism to be used by the Case Management Supervisor and Medical Director to evaluate active cases for consistency, quality and cost effectiveness. Attachment A is a good example of quality assurance performed on 55 closed State of Montana cases in 1998.

6. Refine reports to demonstrate UM effectiveness.

VRI's report format outlines the intervention, cost of anticipated care, cost of contracted care, and the savings realized. VRI moved away from a lengthy two to four-page report to this abbreviated report for efficiency and to maintain patient confidentiality. A copy of our summary report format is provided as Attachment E. In the actual case documentation, all negotiations and savings are identified. The State of Montana can request a complete copy of our case records or request a detailed written in-depth report for specific needs. We are aware of upcoming compliance issues regarding patient rights for protection of confidential medical information with the Heath Insurance Protection Portability Act. That law goes into effect by either August, 1999 or February, 2000.

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
1, 2, 4, 9, 10

7. Research State's benefit limitations and relay to patient prior to offering extra-contractual benefits.

Extra-contractual benefits must be used sparingly. Extra-contractual plans must be approved and endorsed by the State of Montana group leader. VRI works closely with the group leader to discuss rationale for extra-contractual planning and potential revision of the benefit document. Here is an example:

- *A patient/provider requested a specialized obesity program which employed surgical gastric banding. This was not a covered benefit due to the diagnosis of obesity. Case Management researched the possible medical complications due to obesity and possible future medical expenditures. Case Management developed a comprehensive treatment plan which included counseling, exercise, and surgery to address obesity. This program was applied to the regular benefit. Subsequently, the State of Montana has added once-in-a-lifetime coverage for the treatment of obesity.*

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
2, 3, 4, 5, 6, 8, 9, 10

8. Suggest, research and implement financial options for patients with long-term needs.

VRI Case Managers work directly with the patients to assist them in obtaining Medicare, Medicaid or Social Security if the individual's disease or injury appears to be long term. VRI also identifies any other resource or insurance coverage related to the individual's illness or injury. Examples include injuries which may have arisen from a work-related incident, an occupational disease, or an automobile accident. Additionally, VRI has a fully staffed 24-hour Resource Center that tracks the availability of community resources. This Resource Center, together with our Employee Assistance Program, is utilized for patients with long-term needs. An overview of Case #8 follows:

> *A 64-year-old man was admitted for symptoms of low blood sugar. He also had heart failure, leg ulcers, diarrhea, and high blood pressure. Because he had been incapacitated for over a year prior to this hospitalization, the Case Manager was able to identify Medicare eligibility and thereby save money for the State of Montana.*

For case samples that support VRI's response to this recommendation, please refer to case numbers:
2, 3, 8, 9

9. Stand by recommendations of non-certification for continued stay or admissions.

For a hospitalization to be approved, a patient must meet nationally recognized criteria. If criteria are not met, the case is referred to the VRI Benefit Coordination Team in conjunction with the Physician Advisor. This team reviews all impending denials for cost-effective alternatives within the existing benefit structure. If no options to hospitalization are identified, VRI's Physician Advisor reviews the case and discusses the situation with the attending physician. If criteria still are not met, hospitalization is denied. At the same time, the patient is informed of a right to appeal. During this process, an efficient treatment plan usually emerges. Denials are reversed only through appeal or by intervention of the group leader. Case #6 illustrates the denial process:

> *A 62-year-old woman was admitted for depression. The Physician Advisor determined that there was no danger necessitating inpatient hospitalization. After negotiation with the attending psychiatrist, day treatment and EAP were employed as cost-saving alternatives.*

For case samples that support VRI's response to this recommendation, please refer to case numbers:
3, 5, 6

10. Tighten screening criteria for inpatient rehab care.

VRI established a Rehabilitation Team in 1997 to evaluate potential admissions to acute rehabilitation units. This team of nurses and doctors, who are skilled in rehabilitation issues, reviews all cases for medical necessity. The Rehab Team compares inpatient rehabilitation with other options, e.g., transitional care units, skilled nursing facilities, outpatient rehabilitation programs, and home therapies. Most cases get an on-site assessment to insure that valid clinical information is used. Rehabilitation assessment criteria include:

- The patient must have a medical condition which has stabilized and can be helped by rehabilitation, e.g., stroke or spinal cord injury. The goal is to restore the individual to his/her maximum function and independence.
- The patient must be able to participate in rehabilitation activities for at least three hours every day.
- The patient should be functioning at a high enough cognitive level (level six on the Ranchos Amigos Scale) to benefit.
- Patients are seldom certified for admission to a rehabilitation unit on a Friday, because most units are not well staffed to initiate therapy for new patients on weekends.

Prior to this screening, patients were being directed prematurely or inappropriately to inpatient rehabilitation. VRI's evaluation program has been successful in directing patients to the most appropriate level of care. A copy of our Rehabilitation Protocol is provided as Attachment F.

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
2, 3, 9

11. Work with BCBS to obtain a monthly "high/large claims report."

VRI and BCBS Montana are combining efforts to cross-reference claims data and Case Management efforts. BCBS Montana receives a Health Management Report that identifies individuals by total paid dollars (cases with an aggregate of as low as $25,000 are screened). Individuals are grouped by dollar limits or disease category. These reports can then be crossed reference with our Case Management reports so that any high/large claim can be verified to have Case Management activity.

12. Physician Advisors to document investigation/innovative problem solving of alternative options.

VRI's Physician Advisors routinely discuss the medical details of cases with the patient's attending physician. Physician Advisors are involved in all cases which do not meet acute hospitalization criteria or are not making satisfactory progress while in the hospital. Physician involvement is often documented in Utilization Management notes as well as in Case Management notes.

For case samples that support VRI's response to this recommendation, please refer to case numbers:
1, 2, 3, 5, 6, 10

13. Re-work the bill matching/research functions of Case Managers.

Case Managers are too expensive to function simply as claims adjudicators to match charges with contracts. VRI has explored other options, but some Case Manager review is essential for closing the audit loop to prevent misallocation of funds. Many of these cases and the resulting bills are complex. The Case Manager is the only person who knows the patient's medical needs and the nature of the services rendered. Without close scrutiny, overpayments could occur. It is unfortunate that medical billing has so many opportunities for upcoding and unbundling. Nevertheless, VRI has taken the initiative with BCBS Montana to have claims department clerks do the matching and return mismatches to the Case Managers for further attention.

14. Consider the recommendations for improvement in contract compliance as outlined in the Contracted Case Management Services of this audit report.

C-1 Produce ongoing reports detailing number of cases selected for screening.

After a three-month review of cases screened during 1997, the numbers screened remained constant. Five percent of screened cases are actually opened to Case Management. Ten to fifteen State of Montana cases from the pre-certification system are screened each day. The screening includes calls to facility discharge planners, physician office staff for treatment plans and updates, and calls to the family of the patient. If the case does not need management, a letter with the Case Manager's business card is sent to let the patient know that he/she has had attention and to keep the door open for help if difficulties arise. The group leader receives weekly reports of all cases opened and closed.

C-3a Document/articulate goals for each case.

As described in recommendation number 5, VRI has a formal Quality Assurance (QA) program. This program reviews closed cases. One particular item for review is the verification that goals were documented. We have been pleased with our Case Managers' efforts in this area. Our audit of State of Montana cases closed between January 1 and June 24, 1998 shows 93% compliance (see Attachment A).

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
1, 2, 3, 4, 7, 8, 9, 10

C-5b Amend contract to release VRI from responsibility for consent forms.

The Case Management program is voluntary. VRI obtains verbal consent, but does not require written consent forms. If medical records are needed from facilities, written permission to release information is obtained from the patient. When contracts are written, the initial contract is sent by certified mail. The patient is notified to call immediately if there is a problem with the contract. This increased flexibility allows Case Management services to start immediately.

C-5d Limit use of extra-contractual benefit overrides to both picking up the patient's coinsurance responsibility and adding benefits where the plan design has a fixed limit.

Waiver of coinsurance responsibility is not offered unless the family would refuse to use the benefit without the waiver due to financial hardship. In addition, the patient must be at risk for readmission or at risk for other more costly covered benefits to obtain a coinsurance waiver. Some vendors discount more if Case Management pays 100%, because they prefer not to bill the patient. This can be a bargaining chip to obtain lower prices from vendors.

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
2, 4, 7, 8, 9, 10

C-i Amend contract wording so VRI can stop Case Management services when no further impact is apparent.

This has not been an issue and was not an issue in the recent audit. If Case Management determines services are no longer necessary, the case is closed. On difficult cases, the group leader is made aware of case closures where the patient requests further assistance. The facts are presented to the group leader for an administrative decision.

For case samples that support VRI's response to this recommendation,
please refer to case numbers:
1, 2, 3, 4, 7, 8, 10

Exhibit 2 — VRI's Vendor List

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Absarokee

DME
* Healthone System 252-2201 or 252-2988
* Action Medical 655-9669

Home Infusion
+ Healthquest 652-5566 or 1-800-745-4872

Personal Care Homes
Brookside Personal Care 328-4757

Anaconda

DME
* Healthone System 1-800-330-0307

Home Health Agencies
Area V Home Health 563-3550
Heritage Home Health Care 563-3535
Westmont 256-5711

Home Infusion
+ Partners' Solutions 721-6112

Hospice
Anaconda Pintler Hospice 562-5422
Community Hospital of Anaconda 563-5261

Long Term Care Facilities
Community Nursing Home of Anaconda 563-8417

Physical Therapists
* Anaconda Physical Therapy Center 563-2420

Baker

Home Health Agency
Community Health Services 778-3331

(Baker Cont.)

Long Term Care Facility
Fallon Medical Complex Nursing Home 778-3331

Belgrade

DME
* Lincare 388-7265

Home Health Agencies
Bozeman Deaconess Home Care 585-1099
Westmont 256-5711

Home Infusion
+ At Home Solutions 255-7463

Personal Care Homes
Open Arms Elder Care 388-1052
The Dutch Hearth 284-6935

Bigfork

DME
* Norco Medical 549-2321 or 1-800-824-0533

Home Infusion
+ Outpatient Solutions 752-4545
+ Partners' Solution 721-6112

Long Term Care Facility
o Lake View Care Center 837-5041

Big Sandy

Home Health Agency
Big Sandy Medical Center Home Care 378-2188

Long Term Care Facilities
Big Sandy Medical Center 378-2188
Tri-County Care Center Inc. 378-2402

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Big Timber

DME
* Healthone System 1-800-330-0307
* Action Medical 1-800-785-1119

Home Health Agency
Westmont 443-4140

Home Infusion
+ Healthquest 652-5566 or 1-800-745-4872
+ At Home Solutions 255-7463

Long Term Care Facility
Pioneer Medical Center 932-4603

Billings

DME
* Action Medical 655-9669
* Big Sky Orthopedics 259-4678
* Billings Comfort Shoes 245-7848
* Billings Orthopedic 259-3577
* Deaconess Billings Clinic Home Oxygen & Medical Equipment 657-4999
* Healthone System 252-2201 or 252-2988
* Lincare 652-0771
* Westmont 256-5711

Home Health Agencies
Healthy at Home Care Services 652-2311
Rocky Mountain Home Care 652-8883
Senior Helping Hands 259-3111
Yellowstone VNS 256-2757
Westmont 256-5711
Easter Seals Home Care 252-9600

Home Infusion
+ At Home Solutions 255-7463
+ Healthquest 652-5566 or 1-800-745-4872

Hospice
Big Sky Hospice 248-7442

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Billings Cont.)

Long Term Care Facilities

Aspen Meadows 656-8818
DMC TCU 657-4000
o Eagle Cliff Manor 245-9330
Evergreen Billings Health & Rehab Center 252-6135
Glendeen Care Center 252-6135
o Parkview Care Center 259-8000
St. John's Lutheran Home 656-2710
St. Vincent Hospital & Health Center TCU 657-7000
Valley Health Care Center 656-5010
Western Manor Health Care 656-6500

Personal Care Homes

Apple Hill Personal Care 254-2851
Aspen Meadows Retirement Community 656-8818
Autumn Care Center 656-2434
Hico Care 256-3236
Primrose Personal Care 248-9943
River Ridge Not Listed
Westpark Village Retirement Center 652-4886

Physical Therapists

* Amendola, Mark, PT 245-6513
* Bloyder, Joe, PT 245-6513
* Dolan, Bill, PT 238-2500
* Flaming, Lisa, PT 252-0717
* Follett, Michael, PT 656-2710
* Gognon, Robert, PT 245-6513
* Hendricks, Lance, PT 248-8804

Bozeman

DME

* Action Medical 1-800-785-1119
* Bozeman Orthopedic 586-9135
* Healthone System 1-800-330-0307
* Lincare 1-800-280-8112
* Montana Medical Brace, Inc. 586-8440
* Price Rite Drug Centers 587-0608

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Bozeman Cont.)

Home Health Agencies

Bozeman Deaconess Home Care 585-1099
Headwaters Home Health 587-4486
Wel-Home Health 587-2218
Westmont 586-1886

Home Infusion

+ At Home Solutions 587-1050
+ Healthquest 652-5566 or 1-800-745-4872

Hospice

Gallatin Hospice 585-1099

Long Term Care Facilities

Evergreen Bozeman Health & Rehab Center 587-4404
Gallatin Rest Home 582-3300
o Mountain View Care Center 587-2218

Personal Care Homes

Bear Creek Respite Care Center 586-2262
Hamilton House 586-9459
Hillcrest Retirement Community 587-4411
Leisure House 587-4629
Spring Meadows 587-4570

Physical Therapists

* Eisenschenk, Julie, PT 587-2218
* Gurnett, Margaret, PT 585-1200
* Hickman, Toni, PT 587-2218
* Kuntzelman, Rick 585-7399
* Shelbey, Eric, PT 586-2283

Browning

Home Health Agency

Westmont 443-4140

Long Term Care Facility

Blackfeet Nursing Home 338-2686

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Butte

DME
* Healthone System 1-800-330-0307
* Norco Medical 549-2321 or 1-800-824-0533

Home Health Agencies
Beta Factor Home Care 782-9089
City-County Home Health 723-3282
Heritage Home Care - Silver Bow, Inc. 782-6060
Westmont 494-2045

Home Infusion
+ Home IV Pharmacy 494-5693

Hospice
Easter Seals/Highland Hospice 723-5780

Long Term Care Facilities
Butte Convalescent Center 723-6556
Crest Nursing Home 494-7035
Evergreen Butte Health & Rehab Center 723-3225
St. James Community Hospital TCU 723-2737

Personal Care Homes
Bee Hive Homes of Butte 494-8256
Casteil Home 494-6520
In Home Care 782-90004

Physical Therapists
Hoard, Mark, PT 782-1286
Crest Therapy Service

Choteau

DME
Norco Medical 549-2321 or 1-800-824-0533

Home Health Agency
Westmont 446-2271

Long Term Care Facility
Teton Medical Center Nursing Home 466-5763

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Personal Care Home
Chateau Bee Hive Homes 466-5559

Chester

Home Health Agency
Liberty Co. Home Health 759-5181

Long Term Care Facility
Liberty Co. Nursing Home 759-5181

Personal Care Home
Liberty Co. Personal Care 759-5181

Chinook

Home Infusion
+ Healthquest 652-5566 or 1-800-745-4872

Long Term Care Facility
Sweet Memorial Nursing Home 357-2549

Circle

Long Term Care Facility
McCone County Nursing Home 485-3381

Clancy

Long Term Care Facility
Hillbrook Care Center 933-8311

Personal Care Home
Rocky Mountain Retreat 443-1288

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Columbia Falls

Home Infusion Agencies
+ Outpatient Solutions 752-4545
+ Partners' Solutions 721-6112

Long Term Care Facility
Montana Veteran's Home - Nursing Home 892-3256

Columbus

DME
* Action Medical 1-800-785-1119
* Lincare 1-800-280-8112

Home Health Agencies
Columbus Home Health 771-5848
Stillwater Community Hospital Home Health 322-5316
Wel-Care Not Listed
Wel-Home Health 322-5342

Home Infusion
* Healthquest 652-5566 or 1-800-745-4872

Hospice
Stillwater Convalescent Center Hospice 322-5342

Long Term Care Facilities
Stillwater Community Hospital ECU 322-5316
Stillwater Convalescent Center 322-5342

Conrad

Home Health Agencies
Pondera Home Health Agency 278-5566
Westmont 443-4140

Home Infusion
Spectrum 727-1218 or 1-800-828-1701

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Conrad Cont.)

Hospice
Peace Hospice of Montana 287-5566

Long Term Care Facility
Pondera Medical Center LTC 278-3211

Corvallis

Home Infusion
+ Partners' Solution 721-6112

Personal Care Homes
Aaron Care Home 961-3458
Hoffer House 961-4800

Culbertson

Home Health Agency
Roosevelt Memorial Home Health 787-6281

Long Term Care Facility
Roosevelt Memorial Nursing Home 787-6281

Cut Bank

DME
* Lincare 1-800-280-8112

Home Health Agencies
Glacier Medical Home Health Agency 873-2251
Westmont 873-2420

Home Infusion
Spectrum 727-1218 or 1-800-828-1701

Long Term Care Facility
Glacier Co. Medical Center Nursing Home 873-2251

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Deer Lodge

Home Health Agencies
Heritage Home Health Care 846-3200
Powell Co. Memorial Hospital HHA 846-2212

Home Infusion
Partners' Solution 721-6112

Hospice
Hospice at Powell County 846-3975

Long Term Care Facilities
Colonial Manor of Deer Lodge 846-1655
Powell Co. Memorial Hospital 846-2212

Physical Therapists
* Colbo, Kelson, PT 846-1991
* McCarthy, Donna, PT 846-3448
* McGillis, Joseph, PT 846-1991

Dillon

DME
* Norco Medical 549-2321 or 1-800-824-0533
Dillon Medical Supply 683-6848

Home Health Agencies
Barrett Memorial Hospital Home Care 683-3000
Heritage Home Health Care 683-6565
Westmont 683-5136

Home Infusion
+ At Home Solutions 255-7463

Long Term Care Facility
Parkview Acres Care & Rehab Center 683-5105

Personal Care Home
Bee Hive of Dillon 683-2902

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Drummond

Home Health Agency
Granite Co. Home Health 288-3627

Home Infusion
+ Partners Solution 721-6112
+ Healthquest 652-5566 or 1-800-745-4872

Ekalaka

Long Term Care Facility
Dahl Memorial Nursing Home 775-8730

Ennis

Home Infusion
+ At Home Solutions 255-7463

Hospice
Madison Valley Hospital Hospice 682-4274

Long Term Care Facility
Madison Valley Manor 682-7271

Eureka

Long Term Care Facility
Mountain View Manor Good Samaritan 296-2541

Forsyth

Long Term Care Facility
Rosebud Health Care Center - Nursing Home 356-2161

Physical Therapist
Wright, George, PT 1-800-767-5719

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Fort Benton

Home Health Agency
Missouri River Medical Center HHA 622-3331

Long Term Care Facility
Missouri River Medical Center - Nursing Home 622-3331

Personal Care Home
Missouri River Medical Center - PC 622-3331

Glasgow

DME
* Home Oxygen Sales & Service 228-4351

Home Health Agencies
Frances Mahon Deaconess Hospital HHA 228-4351
Hi-Line Home Programs 228-9431
Westmont 228-9777

Long Term Care Facility
Valley View Home 228-2461

Personal Care Home
Our Place 228-8520

Glendive

DME
F & G Pharmacy 365-5665
* Healthone System 252-2201 or 252-2988

Home Health Agencies
Dawson Co. Home Health 365-5213
Glendive Medical Center Home Care 365-3306

Hospice
Glendive Medical Center Hospice 365-3306

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Glendive Cont.)

Long Term Care Facilities

Eastern Montana Veteran's Home 365-8855
Eastern Montana Human Services Center 365-6001
Glendive Medical Center Nursing Home 365-5692

Personal Care Home

Carolyn's Care Center 365-5918

Great Falls

DME

* Healthone System 1-800-330-0307
* Beltone Hearing Aid Center 761-2716
* Summit Prosthetics and Orthotics 761-8408

Spectrum Medical 727-9322
Western Medical Supply 727-7611

Home Health Agencies

Beneifs Health Care - Benefis HH East 455-5378
Benefis Health Care - Benefis HH West 771-5840
Interim Healthcare of Cascade County 771-7000
Medallion Medical Care 454-3883
Westmont 761-7800

Home Infusion

+ Spectrum Home Solutions 727-1218
+ Healthquest 652-5566 or 1-800-745-4872

Hospice

Peace Hospice of Montana 727-6161

Long Term Care Facilities

Benefis Skilled Nursing Center 761-1200
Missouri River Manor 761-6467
Park Place Health Care Center 761-4300

Personal Care Homes

Alternate Personal Care of Great Falls 761-7089
Cambridge Court 727-7151
Great Falls Personal Care 452-5810
MT. West Retirement Home, Inc. 452-6302
The Rainbow Retirement Community - PC 761-6661

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Great Falls Cont.)

Physical Therapists

* Hallett, Traci, PT 761-0471
* Jensen, Michael, PT 453-5555
* Monheim, Jolene, PT 711-0777
* Swift, Jeff, PT 453-5555

Hamilton

DME

* Norco Medical 549-2321 or 1-800-824-0533

Home Health Agencies

Interim Health Care of Montana 363-7200
Marcus Daly Memorial Hospital Home Health Agency 363-6503
Westmont 363-4778

Home Infusion

Health Care Plus 363-6224
+ Partners Solution 721-6112

Hospice

Marcus Daly Memorial Hospice of Bitterroot 363-6503

Long Term Care Facilities

Marcus Daly Memorial Hospital TCU 363-2211
The Discovery Care Center 363-2273
Valley View Estate Health Care Center 363-1144

Personal Care Home

The Discovery Care Center 363-2273

Hardin

DME

* Action Medical 1-800-785-1119
* Lincare 1-800-280-8112

Home Health Agencies

Big Horn Memorial Home Health Care 665-3446
Westmont 665-1411

*** BCBS Par Prov**
\+ VRI Pricing Agreement
o Lantis

(Helena Cont.)
* Sears, Ursula, RPT 442-0808
* Tureck, Stacy, PT 457-0480

Kalispell

DME
* Healthone System 1-800-330-0307
* Norco Medical 752-4804 or 1-800-458-0095
Kalispell Medical Equipment 752-6111

Home Health Agencies
Flathead Co. Home Health
Home Options Home Health 752-8689
Westmont 756-8155
Wel-Care

Home Infusion
+ Outpatient Solutions 752-4545

Hospice
Home Options Hospice 752-8667

Long Term Care Facilities
Brandon House 752-5460
o Heritage Place 755-0800
Immanuel Lutheran Home 752-9622

Personal Care Homes
Bee Hive Home of Flathead Co. 755-4483
Friendship House 257-8375
Windward Place 257-2549

Physical Therapists
* Breuer, Andrea , PT 756-7878
* Bartels, Margaret, PT 756-7878
* Brakefield, Susan, PT 756-7878
* Corwin, Julie, PT 857-2218
* Gibbs, Timothy, PT OCS 756-7878
* Lavin, Anita, PT 756-7878
* Lepper, Fred, PT 756-7878
* Rucinski, Susan, PT 756-7878
* Upton, Stacy, PT 756-7878
* Wyman, Laura, PT 756-7878
* Buffalo Hills Physical Therapy

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Laurel

DME
* Action Medical 655-9669 or 1-800785-1119
* Healthone System 252-2201 or 252-2988 or 1-800-330-0307

Home Health Agencies
Healthy at Home Care 652-2311
Ruby Mountain Home Care Unlisted
Easter Seals Home Care 252-9600
Westmont 256-5711
Yellowstone VNS 256-2757

Home Infusion
+ Healthquest 652-5566 or 1-800-745-4872
+ At Home Solutions 255-7463

Hospice
Big Sky Hospice 248-7442

Long Term Care Facilities
Laurel Care Center 628-8251
Evergreen Laurel Health & Rehab Center 628-8251

Personal Care Homes
Betty's House 628-9011

Physical Therapy
* Hadley, Patricia, PT 628-8440

Lewistown

DME
* Action Medical 1-800-785-1119
* Central Montana Medical Center 538-6302

Home Health Agencies
Central Montana Medical Center Home Health 538-7711
Westmont 538-2548

Home Infusion
+ At Home Solutions 255-7463
+ Healthquest 652-5566 or 1-800-745-4872

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Lewistown Cont.)

Hospice

Hospice of Central Montana 538-7711

Long Term Care Facilities

Central Montana Skilled Nursing Center 538-7711
Montana Mental Health Nursing Care Center 528-7451
o Valle Vista Manor 538-8775

Personal Care Homes

Sunrise Personal Care Home 538-2415
The Villa 538-8775

Physical Therapist

* Kuykendall, Gary, PT 538-8775

Libby

DME

* Home Medical Oxygen 293-6746
* Lincare 1-800-280-8112
* Norco Medical 549-2321 or 1-800-824-0533

Home Health Agencies

Libby Home Health Care 293-6285
St. John's Lutheran Home Health Services 293-7761
Westmont 443-4140

Home Infusion

+ Outpatient Solutions 752-4545
+ Partners Solution 721-6112

Hospice

Kootenai Volunteer Hospice 293-3923

Long Term Care Facility

Libby Care Center 293-6285

Personal Care Home

St. John's Personal Care Home 293-7761

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Livingston

DME
* Action Medical 1-800-785-1119
* Lincare 1-800-280-8112

Community Home Oxygen 222-1080
* Mountain Air

Home Health Agencies
Livingston Memorial Home Care 222-3541
Westmont 222-8527

Home Infusion
+ At Home Solutions 255-7463
+ Healthquest 652-5566 or 1-800-745-4872

Hospice
Gateway Hospice 222-3541

Long Term Care Facility
Livingston Health & Rehab 222-0672

Personal Care Homes
Diamond K Lodge 222-0605
Frontier Personal Care, Inc. 222-6102

Physical Therapists
* Cadby, Todd, PT 222-7231
* Hukill, Michelle, PT 222-9412
* Westerberg, Richard, PT 222-7231

Malta

DME
Action Medical 654-2535

Home Health Agencies
Phillips Co. Hospital Home Health 654-1100
Westmont 654-1100

Long Term Care Facility
Phillips Co. Good Samaritan Retirement Center 654-1190

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Miles City

DME
* Action Medical 1-800-785-1119
* Healthone System 1-800-330-0307

Home Health Agencies
Holy Rosary Hospital Home Care 232-3810
Wel-Home Health 232-2687
Westmont 443-4140

Home Infusion
+ Healthquest 652-5566 or 1-800-745-4872

Long Term Care Facilities
o Friendship Villa Care Center 232-2687 or 232-2730
Holy Rosary ECU 232-2600

Personal Care Homes
Cottonwood Care Home
Homestead Elderly Care 232-6670
TLC of Miles City, Inc. 232-7988

Physical Therapist
* Cunningham, Elizabeth, PT 232-2687

Missoula

DME
* Healthone System 1-800-330-0307
* Norco Medical 549-2321 or 1-800-824-0533
Harrington's Medical Supply 721-8468 or 1-800-358-8468

Home Health Agencies
Partners in Home Care 728-8848
Westmont 728-5843
Nightingale Nursing 543-8749
Interim Health Care 549-7000
Healthy at Home Care Services

Home Infusion
+ Healthquest 652-5566 or 1-800-745-4872
+ Partners' Solution 721-6112

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Missoula Cont.)

Hospice

Partners in Home Care Inc. Hospice 728-8848

Long Term Care Facilities

Community Medical Center TCU 728-4100
Evergreen Missoula Health & Rehab Center 549-0988
Hillside Manor 251-5100
Riverside Health Center 721-0680
St. Patrick's Hospital TCU 546-7271
The Village Health Care Center 728-9162

Personal Care Homes

Bee Hive Home of Missoula 543-0345
Edgewood Vista of Missoula 549-9660
Evergreen at Missoula 543-2273
Flor-Haven Home 542-2598
Golden Age 549-2605 or 728-0783
Hawthorne House 543-5044
Hillside Place 251-5100
Maplewood Manor 549-8127
The Village 549-1300

Philipsburg

Home Health Agency

Heritage Home Health Care 443-2186

Home Infusion

+ Partners' Solution 721-6112

Long Term Care Facility

Granite Co. Memorial Nursing Home 859-3271

Plains

Home Health Agency

Clark Fork Valley 826-3601
Westmont 443-4140

Home Infusion

+ Partners' Solution 721-6112

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Plains Cont.)

Long Term Care Facility
Clark Fork Valley Nursing Home 826-3601

Personal Care Home
New Horizons Assisted Living 826-5599

Plentywood

Home Health Agency
Sheridan Memorial Home Health 765-1420

Long Term Care Facility
Sheridan Memorial Home Health 765-1420

Personal Care Home
La Casa Personal Care 765-1669

Polson

DME
* Norco Medical 549-2321 or 1-800-824-0533

Home Health Agencies
Home Caregivers
St. Joseph Home Health 883-5273
Lake County Home Health 883-7800
Westmont 883-3618

Home Infusion
Health Care Plus 883-3838
+ Outpatient Solutions 752-4545

Long Term Care Facilities
Evergreen Polson Health & Rehab Center 883-4378
Orchard View 883-4860
St. Joseph Convalescent Center 883-4378

Personal Care Home
St. Joseph Assisted Living 883-1011

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Polson Cont.)

Physical Therapist

* Gullotta, Daniel, PT 883-8101

Poplar

Home Health Agency

Roosevelt Co. Home Health Care 787-6281

Long Term Care Facility

Northeast Montana Health Services Inc. 768-3452

Red Lodge

DME

* Action Medical 1-800-785-1119
* Lincare 1-800-280-8112

Home Health Agencies

Carbon Co. Memorial Home Care 446-2345
Westmont 446-2563

Home Infusion

+ At Home Solutions 255-7463
+ Healthquest 652-5566 or 1-800-745-4872

Long Term Care Facilities

Carbon County Memorial Nursing Home 446-2345
o Cedar Wood Villa 446-2525

Ronan

DME

* Mission Valley Oxygen 676-5510

Home Health Agency

Lake County Home Health 676-4441

Home Infusion

+ Outpatient Solutions 752-4545
+ Partners' Solution 721-6112

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

(Ronan Cont.)

Hospice

Lake County Home Health Hospice 883-7300

Long Term Care Facility

St. Luke Community Nursing Home 676-2900
Westside Care Center 676-5510

Roundup

DME

* Action Medical 1-800-785-1119
* Lincare 1-800-280-8112
* Bartow Welding 323-2532

Home Health Agency

Roundup Memorial Hospital & Nursing Home 323-2302

Home Infusion

+ Healthquest 652-5566 or 1-800-745-4872

Long Term Care Facility

Roundup Memorial Hospital & Nursing Home 323-2302

Scobey

Home Health Agencies

Daniels Memorial Home Health 487-2296
Westmont 655-9669

Long Term Care Facilities

Daniels Memorial Nursing Home 487-2296

Shelby

Home Health Agency

Marias Medical Center Home Health 434-5536

Long Term Care Facility

Marias Medical Center 434-3261

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Sheridan

Home Health Agencies
Ruby Valley Home Care 842-5254
Westmont 443-4140

Home Infusion
+ At Home Solutions 255-7463

Long Term Care Facility
Tobacco Root Mountains Care Center 842-5600

Sidney

DME
Duramed Plus 482-7841

Home Health Agency
Sidney Health Center HHA 482-2120

Hospice
Sidney Health Center Hospice 482-2120

Long Term Care Facility
Sidney Health Care ECU 482-2120

Stevensville

Home Infusion
+ Partners Solution 721-6112

Long Term Care Facility
Bitterroot Valley Living Center 777-5411

Personal Care Home
Bitterroot Valley Living Center 777-2022

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Superior

Home Infusion
+ Partners' Solution 721-6112

Long Term Care Agency
Mineral Community Nursing Home 822-4841

Personal Care Home
Mountain View Village 822-4841

Thompson Falls

DME
* Norco Medical 549-2321 or 1-800-824-0533

Home Health Agency
Westmont 827-9443

Home Infusion
+ Outpatient Solutions 752-4545
+ Partners Solution 721-6112

Townsend

DME
* Lincare 1-800-280-8112

Home Health Agency
Broadwater Health Center HHA 226-3196
Westmont 226-4035

Home Infusion
+ Home Link 444-2350 or 1-800-717-7744

Long Term Care
Broadwater Health Center Nursing Home 266-3186

Personal Care Home
Broadwater Co. Rest Home 266-3711

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Whitehall

DME
* Lincare 1-800-280-8112

Home Health Agency
Westmont 225-3302

Whitefish

Home Health Agency
Flathead Co. Home Health 862-9030

Home Infusion
+ Outpatient Solutions 752-4545

Long Term Care Facilities
Colonial Manor of Whitefish 862-3557
North Valley Hospital ECU 862-2501

White Sulphur Springs

Home Health Agencies
Mountain View Home Health Agency 547-3321
Westmont 443-4140

Long Term Care Facility
Mountain View Medical Center Nursing Home 547-3321

Wolf Point

Home Health Agency
Hi-Line Health 653-1340
Westmont 443-4140

Long Term Care Facilities
Northeast Montana Health Services Faith Lutheran Home Campus 653-1400

Personal Care Home
Harada House 653-3996

*** BCBS Par Prov**
+ VRI Pricing Agreement
o Lantis

Exhibit 3 — Vendor Summary

NUMBER AND TYPE OF VENDORS UNDER PRE-NEGOTIATED CONTRACT FOR USE BY VRI CASES MANAGERS

(Data tallied according to information submitted by VRI July 1998)

Location	Durable Medical Equipment (DME)			Home Health Agencies			Home Infusion Therapy Agencies			Hospice			Long Term Care			Personal Care Homes			Physical Therapists		
	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None
Absarokee	2							1										1			
Anaconda	1					3		1				2			1				1		
Baker						1									1						
Belgrade	1					2		1										2			
Bigfork	1							2						1							
Big Sandy			1												2						
Big Timber	2					1		2							1						
Billings	8					6		2				1		2	8			7	7		
Bozeman	6					4		2				1		1	2			5	5		
Browning						1									1						
Butte	2					4		1				1			4			3			2
Choteau			1			1									1			1			
Chester						1									1			1			
Chinook								1							1						
Circle															1						
Clancy															1			1			
Columbia Falls								2							1						
Columbus	2					4	1					1			2						
Conrad						2			1			1			1						
Corvallis					1													2			
Culbertson						1									1						
CutBank	1					2			1						1						
Deer Lodge						2			1			1			2	3					

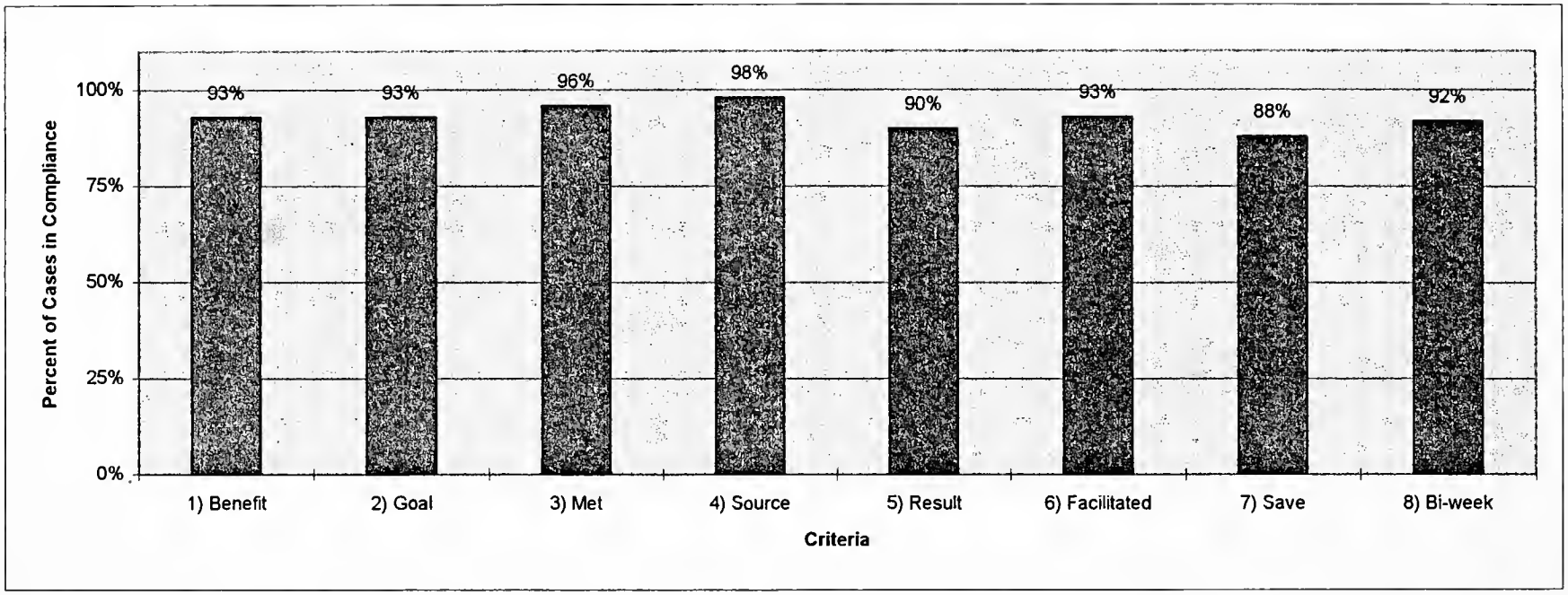
Location	Durable Medical Equipment (DME)			Home Health Agencies			Home Infusion Therapy Agencies			Hospice			Long Term Care			Personal Care Homes			Physical Therapists		
	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None
Dillon	1		1			3		1							1			1			
Drummond			1		2																
Ekalaka															1						
Ennis					1							1			1						
Eureka															1						
Forsyth															1						1
Fort Benton						1									1			1			
Glascow	1					3									1			1			
Glendire	1		1			2						1			3			1			
Great Falls	3		2			5		2				1			3			5	4		
Hamilton	1					3		1	1			1			3			1			
Hardin	2					2		1				1			2						
Harlowton						1									1						
Havre			1			2		1				1			1			1			
Helena	2		2			3		2				2		1	3			4	12		
Kalispell	2		1			4		1				1		1	2			3	11		
Laurel	2					5		2				1			2			1	1		
Lewiston	2					2		2				1		1	2			2	1		
Libby	3					3		2				1			1			1			
Livingston	3		1			2		2				1			1			2	3		
Malta			1			2									1						
Miles City	2					3		1						1	1			3	1		
Missoula	2		1			5		2				1			6			9			
Philipsburg						1		1							1						

Location	Durable Medical Equipment (DME)			Home Health Agencies			Home Infusion Therapy Agencies			Hospice			Long Term Care			Personal Care Homes			Physical Therapists		
	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None	BCBS	VRI	None
Plains						2		1							1			1			
Plentywood						1									1			1			
Polson	1					4		1	1						3			1	1		
Poplar						1									1						
Red Lodge	2					2		2						1	1						
Ronan	1					1		2				1			2						
Roundup	3					1		1							1						
Scobey						2									1						
Shelby						1									1						
Sheridan						2		1							1						
Sidney			1			1						1			1						
Stevensville								1							1			1			
Superior								1							1			1			
Thompson Falls	1					1		2													
Townsend	1					2		1							1			1			
Whitehall	1					1															
Whitefish						1		1							2						
White Sulphur Springs						2									1						
Wolf Point						2									1			1			

BCBS Column: represents the number of vendors under a pre-negotiated contract with Blue Cross and Blue Shield of Montana (BCBS).
VRI Column: represents the number of vendors under a pre-negotiated contract with either VRI or another firm named Lantis Corporation.
None Column: represents the number of vendors VRI indicates are available in the location but are not currently under a pre-negotiated contract.
No number in a box means no evidence of a vendor contract in that location.

Exhibit 4 — QA Program Results

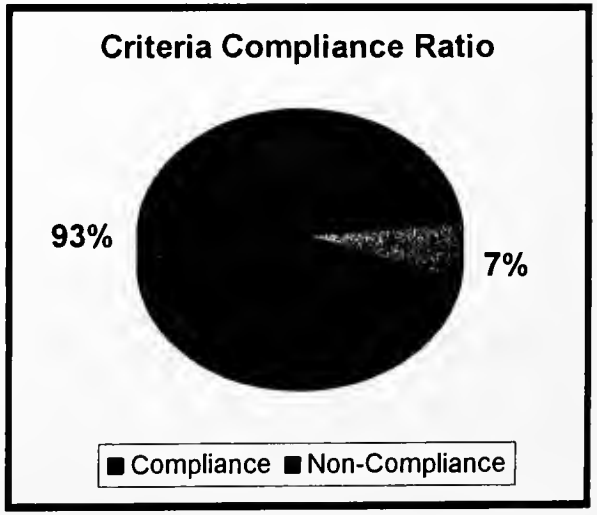
STATE OF MONTANA
Review of Closed Care Management Cases
01/01/98 through 06/24/98



The following criteria/questions were reviewed:

1) Is documentation present that **benefits** were verified at case opening?
2) Were **goals** documented within one week of case opening?
3) Was the goal **met** and documented at case closure?
4) Was the referral **source** documented?
5) Was the **result** or outcome improved for client, and was that documented?
6) Was the original treatment plan identified correctly and were other alternatives **facilitated**?
7) Can cost **savings** be documented by screen documentation?
8) Was **bi-weekly** contact maintained?

Not all of the review criteria were applicable to all cases.
For example, a few patients refused to continue w/ program after being enrolled, some cases were claims issues only, etc.



STATE OF MONTANA
Review of Closed Care Management Cases
01/01/98 through 06/24/98

			1	2	3	4	5	6	7	8
	MGR	DIAGNOSIS	BENEFIT	GOAL	MET	SOURCE	RESULT	FACILITATED	SAVE	BIWEEK
1	SA	Brain cyst	Yes	Yes	NA	Yes	NA	Yes	NA	Yes
2	SP	Osteomyelitis of foot	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	SA	fractured left tibia w/infection	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	KG	Hip surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	SP	Wound dehiscence	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	SA	Pneumonia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	LW	Diabetes	Yes	No	NA	Yes	Yes	Yes	NA	Yes
8	KG	Diabetes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	SA	Knee surgery	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
10	SA	COPD	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11	SP	Diabetes; CABG	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12	KB	paralytic ileus/dehydration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13	SP	Metastatic cancer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
14	CF	deep phlebitis	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
15	SP	Lung cancer; ostomy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16	SA	depression	No	Yes	Yes	Yes	No	Yes	No	Yes
17	LW	Lung cancer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18	SP	Post-op infection	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
19	SA	Multiple sclerosis	Yes	Yes	Yes	Yes	Yes	Yes	No	NA
20	LW	Scapula fracture	Yes	Yes	NA	Yes	NA	Yes	No	Yes
21	CF	Pancreatitis	NA	NA	NA	Yes	NA	Yes	NA	NA
22	LW	Wound dehiscence	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
23	KG	Metastasis to brain	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
24	SP	Orbital cellulitis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
25	SA	DM, CHF, ARF	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
26	JR	Pneumonia, ataxia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
27	VH	Subdural hematoma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
28	SP	Drastematomyelia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
29	SA	psych (adjustment reac noc)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
30	SA	Metastatic cancer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
31	KG	Pancreatic cancer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
32	SA	Epitaxis, ETOH abuse	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
33	LW	Endometrial cancer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

STATE OF MONTANA
Review of Closed Care Management Cases
01/01/98 through 06/24/98

			1	2	3	4	5	6	7	8	
	MGR	DIAGNOSIS	BENEFIT	GOAL	MET	SOURCE	RESULT	FACILITATED	SAVE	BIWEEK	
34	SA	Multiple sclerosis	Yes	Yes	NA	Yes	No	No	No	No	
35	SA	Pneumonia, RA	No	No	Yes	No	Yes	Yes	No	No	
36	JR	CF	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
37	KW	AD-Nonhyperactive	No	Yes	No	Yes	No	No	No	No	
38	DF	Preterm Labor	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
39	JH	Twins (pre eclamp)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
40	JH	Fetal/neonatal jaundice	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
41	DF	brstfeeding/prevent baby readmit	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
42	MH	Preterm Labor	Yes	Yes	NA	Yes	No	Yes	Yes	Yes	
43	JH	preterm Labor	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
44	JH	preterm nb nec/wt nos	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
45	JH	preterm Labor	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
46	JH	gestational diabetes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
47	AB	pregnancy induced hypertension	Yes	Yes	No	Yes	No	Yes	Yes	Yes	
48	JH	hyperemesis, graviderum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
49	JH	preterm newborn and	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
50	JH	acute bronchiolitis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
51	JH	spina bifida, hydrocephalis, macrocephalis, flat closed spine defect	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
52	JH	kidney stones	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
53	DF	gestational diabetes	Yes	Yes	NA	Yes	Yes	No	Yes	Yes	
54	JH	pregnancy induced hypertension	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	
55	JH	resp distress syndrome	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
TOTALS											
	Total Yes		50	50	46	54	47	51	46	49	393
	Total Applicable		54	54	48	55	52	55	52	53	423
	Percentage which met review criteria		**93%**	**93%**	**96%**	**98%**	**90%**	**93%**	**88%**	**92%**	**93%**

Exhibit 5 — VRI's Savings Report Format

Monthly Savings Report

Period: Month/Year: 1-98
Patient's Name: [redacted]
Patients DOB: [redacted]
Subsciber ID: [redacted]
Group Name: Aetna
Group Number: [redacted]

Case Manager: SA
Diagnosis: Osteomyelitis
Physician:
Date Opened: 9-3-97
Date Closed:

Item	Pricing Effective Dates From	To	Pricing Authorization		Frequency	Regular Costs	Per Unit	Total Units	Regular Tot Am't	Negotiated Cost	Per Unit	Total Units	Negotiated Tot Am't	Savings
Skilled RN						123	1	12	(1476)	85.00	1	12	1020.00	456
Supplies													100.00	
Negotiated R&B										300.00	1	7	2100.00	
Discharge Nurse						1421	1	7	1017.00					
Total									$0.00				$0.00	$0.00
Less Monthly ICM Costs									1001700				3220.00	679700

Total Monthly Averted Costs

Case Summary/Comments: Averted lengthy acute care stay by providing for skilled nursing facility for 1 week - then negotiated for out managed the home care nursing.

#1

Exhibit 6 — VRI's Rehabilitation Criteria

REHABILITATION CERTIFICATION - (PROTOCOL 27)

I. POLICY

A. All potential rehabilitation admissions will be referred to the Managed Care Montana Rehabilitation (Rehab) Team. The Rehab Team will review all rehabilitation admissions for medical necessity.

II. PROCEDURE

A. When Pre-certification is involved in a case that appears to have rehabilitation potential, referral needs to be made to the Rehab Team. These cases may be (but are not limited to) head injuries, spinal cord injuries, multiple trauma, CVA's, amputations, surgical complications resulting in functional impairment and severe debilitating illnesses or disease processes such as Guillain Barre and Multiple Sclerosis. The Rehab Team can then begin to address the feasibility of inpatient rehabilitation versus other options such as TCU, skilled nursing facility with therapies, outpatient rehabilitation program and home therapies. Onsite assessments will be made when possible in order to provide the optimum rehabilitation treatment plan for each patient.

When Pre-certification receives an initial admission call requesting rehabilitation, the call is to be referred to the Rehab Team in order to initiate the rehabilitation review process. A Support assistant will load the demographics and open a file line. The Rehab Team Nurse will then begin the clinical review for rehabilitation admission.

The same procedure will apply when Pre-certification has been working an admission that gets a request for transfer to rehabilitation.

When a call is received requesting certification for a rehabilitation admission, the Rehab Team Nurse Reviewer will proceed as follows:

1. It will be necessary to obtain initial information from the caller with a telephone number and call him or her back after certification process is complete. Offer the 800 number for Customer Service to verify rehabilitation benefits.

2. Verify rehabilitation benefits for BCBS business in the LRSP system. See **LRSP Eligibility Verification Protocol**. For

non-BCBS business, refer to appropriate benefits administrator and /or contract.

3. If it becomes evident that rehabilitation benefits may be exhausted or not available, refer to **End of Benefit Protocol**. The Rehab Team Nurse Reviewer may determine if the case is appropriate for consideration of extra-contractual benefits.

4. Determine medical necessity for inpatient rehabilitation treatment:

   a. Patient must have a medical condition of recent onset or recent progression in which rehabilitation will help restore the individual to his/her maximum function and independence.

   b. The patient must be medically stable and able to participate in a total of at least three hours of therapy per day, five days per week. The three hours of therapy do not need to be consecutive, but usually will include three different modalities, such as physical therapy, occupational therapy, and speech therapy. In some cases, there may only be a combination of two modalities totaling at least three hours of therapy per day.

   c. The patient should be functioning at a high enough cognitive level (level 6 on the Ranchos Amigos Scale) to benefit from a comprehensive rehabilitation program.

   d. After obtaining all pertinent information, the Rehab Team Nurse Reviewer will apply Milliman and Robertson rehabilitation criteria and nursing judgment. If the Rehab Team Nurse Reviewer does not feel the patient meets criteria for rehabilitation admission, the information must be sent to the HCA (Health Care Advisor) for approval or denial of the admission. The Rehab Team Nurse Reviewer will make appropriate notification and document that days are at risk.

      1. If the HCA approves the admission, proceed with certification and assign a length of stay LOS.

      2. If the HCA denies the admission, refer to **Certification Denial Protocol**.

3. Specific reason codes have been developed for inappropriate rehabilitation admissions (see attached).

e. After initial certification is complete, notify the BCBS Medical Review department (for BCBS subscribers only) to advise of the proposed admission. If patient was involved in an accident and/or possibly Worker's Comp related, notify the Other Party Liability (OPL) Unit if this has not already been done. Refer to **Other Party Liability Protocol** as needed.

5. Continued Stay Reviews (CSR) will be done on the Last Certified Day (LCD). Refer to **Continued Stay Review Protocol**. The Rehab Team Nurse Reviewer will request information on discharge plans and anticipated discharge date as well as all clinical information needed to determine continued medical necessity. Request a faxed copy of weekly team conference report.

After reviewing the information for CSR, the Rehab Team Nurse Reviewer will refer to the HCA if he/she feels the patient does not meet criteria for continued inpatient rehabilitation stay. The Nurse Reviewer will make appropriate notification and document that days are at risk. The Rehab Team Nurse Reviewer may wish to review the case with the HCA for any of the following reasons, before approving more days:

a. Temporary discontinuance of therapies for any reason.

b. Lack of progress toward stated goals after one week, or between review periods.

c. No functional improvement documented.

d. Patient is not receiving or is unable to tolerate at least three hours of therapy per day.

e. Patient is receiving less than two therapeutic modalities.

f. Patient no longer meets Rehabilitation criteria.

g. Rehab Nurse Reviewer is uncomfortable with certification for any reason.

6. If it becomes apparent that the patient is nearing end of benefits (EOB) during the CSR process, refer to **End of Benefits Protocol**. If the patient is at or very near EOB and the rehabilitation facility is requesting continued inpatient rehabilitation, the Rehab Team Nurse Reviewer may investigate the possibility of extending benefits extra-contractually.

III. SPECIAL NOTES

A. Patients will not routinely be certified for admission to rehabilitation units on Friday.

B. When a patient is transferred from acute care to rehabilitation, a new file line must be added. Likewise, if a patient is transferred from rehabilitation back to acute care, a new file line must be added. Each time a patient is transferred, the BCBS UR Dept. must be notified. Also notify the BCBS UR Dept. when a patient is discharged from rehabilitation.

C. If the patient goes out on an overnight pass, and is not on the hospital's daily midnight census, the Nurse Reviewer must close the current CSR screen using the day the patient leaves as discharge date, and reopen a new file line using the date the patient returns as the date of admission. It is not necessary to recopy documentation, just refer to previous file line in current documentation.

D. The Rehab Team Nurse Reviewer is responsible for notifying the support team member of all rehabilitation admissions, CSR's and discharges.

E. The Rehab Team Nurse Reviewer will be responsible for opening rehabilitation file lines, assigning certification numbers, updating screens for

CSR's using the new information and noting that additional documentation is on the MC2K screen.

F. The Rehab Team Nurse Reviewer will follow all rehabilitation admissions, completing all CSR's until the patient is discharged. It is his/her responsibility to reassign any rehabilitation cases to another Rehab Team nurse member to follow in his/her absence.

G. Special Group and Benefit Considerations:

1. Be aware that some groups treat rehabilitation as a regular illness with no dollar limitations (ex. Federal Employees, with the Federal Employee Plan, known as FEP).

2. Be aware also that outpatient rehabilitation benefits may be included in overall rehabilitation benefit and that medical treatment while inpatient rehabilitation may be paid out of medical benefits rather than rehabilitation benefits. This is for the Nurse Reviewer's information only, (s)he is not responsible for benefits.

3. For FEP subscribers over 65 and retired but FEP primary, review rehabilitation admissions as if the patient were not Medicare eligible. Full reviews with CSR's will be done. See **Medicare Eligibility Protocol**.

4. Some groups have day limit rather than dollar limit for inpatient rehabilitation admissions. Contact the appropriate Customer Service representative for specific group limits.

REHABILITATION CERTIFICATION MCM 27 March 20, 1997

Karen Dunham, RN — April 2, '97

Donna Sparks — April 3, 1997

Procedure Committee Members — Initial Approval Date

Dates Reviewed: 3/6/97 PB

Paul Bogumill
Program Manager MCM/VRI

4/2/97
Initial Approval Date

Exhibit 7 — VRI's Response to Auditor's Draft Report

VRI

A MANAGED CARE COMPANY

August 6, 1998

Nancy Hakes, R.N., M.S.N.
The Segal Company
5080 North 40th St., Ste. 400
Phoenix, AZ 85018

RE: State of Montana Audit Response

Dear Ms. Hakes:

This letter and attached information are in response to your July 24, 1998 correspondence. In that correspondence you have provided VRI with a copy of the draft report to the State of Montana from the Segal Company regarding the audit of our case management services.

Please consider changing the introduction to the "Summary of Findings" table on page nine to read:

> The following table summarizes findings of the review of VRI's compliance with the 1996 Case Management audit recommendations. VRI shows improvement in all eighteen areas of recommendation. There are seven areas that have improved but need more work, and eleven recommendations which evidence satisfactory improvement. This calculates by simple percentage to be 39% of the recommendations needing improvement. These recommendations have not been weighted for degree of importance or priority.

We would also ask that you consider changing the headings on the "Summary of Findings" table on page nine to read:

Current Heading	Proposed Heading
Recommendation Number	no change
Evidence of Improvement	Satisfactory Evidence of Improvement
Needs Improvement	Improved but Needs More Work
No Evidence of Improvement	no change

Additionally, after looking at the following responses please reconsider how they would best fit into the "Summary of Findings" table.

1. *Shift the emphasis of case management efforts from negotiating discounts on individual cases to redirection of patients toward providers where a previously negotiated discount arrangement is in place. With the clout of your review organization (VRI or that of BlueCross BlueShield of Montana, consider developing a comprehensive network of ancillary procedures (e.g. home health, home infusion therapy, hospice, skilled nursing facilities, physical therapy, etc.) for the patients of the State of Montana and for your own use in case management.*

   Clearly, VRI case managers now have access to more vendor discount arrangements than in 1996. . . . Additional contracting efforts are needed . . . in order to assure adequate geographic coverage.

VRI case management has established the following policy **(Attachment A)** about negotiating discounts (paraphrased): Provide appropriate, cost-effective health care services to the client. Do this by determining the patient's needs; using an existing pricing agreement, if there is one; or negotiating if there is no preferred provider agreement. Negotiate after obtaining insight into previous or comparable pricing of services or equipment by talking to other care managers. Share the information with other VRI care managers after negotiations are complete. Attempt to recruit reliable, cost-effective but non-participating providers into the provider discount network.

There are several reasons providers may not be in the VRI/BCBS preferred network for a given area. The reasons include: the provider does not wish to participate; the number of referrals is negligible because the population of the area is tiny, so attempts to sign up the providers would be initiated only when the first patient needs them; the quality of providers is poor, so VRI prefers to direct patients to an adjacent area or to a state-wide provider; no provider exists in the area.

Improvements in the VRI preferred provider network are dramatic. We had virtually no agreements in place in 1996. Now, in addition to the BlueCross BlueShield Preferred Provider Network, we have agreements with:

- Twenty Preferred Providers for DME
- Six Preferred Providers for home infusion
- Forty-five Preferred Providers for physical therapy
- One statewide skilled nursing facility

These providers were summarized for you in Attachment C of our previous response.

Pricing agreements, contracts and network development for ancillary services is a dynamic process. VRI is a subsidiary of BlueCross BlueShield of Montana, and together we are improving the ancillary services network in a rural state with limited resources that can have substantial political, legislative, and contractual issues. We recently sent letters of intent to BlueCross BlueShield to initiate additional skilled nursing agreements. We feel that the intent of this recommendation, specifically to have our case mangers efficiently move through the process by having pre-established pricing arrangements, has been clearly established and improved on since 1996. Thus, it should be categorized in the area of evidence of improvement. This area for any case management company needs to be evolving and continually improved upon.

2. *Consider shifting the emphasis of case management efforts to determine whether the physician or vendor is proposing the most efficient/medically necessary treatment plan and intervene to change a proposed plan to a more creative design and fiscally sound plan, where appropriate. Measure the difference between the plan the health team originally proposed and the new creative one VRI developed.*

Additional information is needed to better demonstrate that VRI treatment plans were more cost effective and different than those originally considered by the patient's physician. We'd like to respectfully request that you review the cases which were presented as examples of this recommendation. Specifically, in the TSO's attached to the examples you will see there is information provided showing the proposed treatment plan, clinically and financially, as well as the one coordinated by VRI. This information is then tabulated into cost savings reports.

By reviewing these cases and incorporating the information on the TSO, I think you will see that our efforts are substantiated.

3. *Develop formal and comprehensive written screening guidelines specific to the kinds of situations confronting case management services (these criteria will be a little different than percent criteria for hospital admissions). Case management criteria should indicate when the review staff can unilaterally approve the use of certain types of durable medical equipment, home health, infusion therapy, home uterine monitoring, skilled services, inpatient rehabilitation, etc. Such criteria should be reviewed by the State to assure that they are in agreement as to why certain services will be authorized, as they are the payor.*

VRI complies with Montana law by filing its utilization review plan with the State of Montana Insurance Commission, including copies of our review criteria (Milliman and Robertson). Those documents are available to the State of Montana for review. For case management, numbering the criteria may improve VRI's efficiency as well as the ease of audit, but VRI is still investigating whether this will improve the quality of services rendered. Please note that VRI documents criteria by a numbering system for our precertification and preauthorization functions. Our quality assurance program reviews precertification and case management to evaluate if criteria was applied and documented appropriately. Provided as **Attachment B** are copies of the computer screens that highlight the data field for collecting the criteria number referenced on our precertification system.

5. *While this QA program addresses some of the 1996 recommendations, there is no evidence the other two recommendations for internal QA review of nurse's application of criteria and Physician Advisor decisions has been implemented.*

We did not explain our QA process thoroughly enough when we said VRI had a company wide QA program. **Attachment C** is a flow chart detailing the entire QA program for our "managed care" division. Our QA program evaluates the care mangers' application of criteria, analysis of decisions, and protocol implemented by our Physician Advisors.

11. *VRI indicates they are working with BCBSMT to combine efforts to cross reference claims data and case management efforts. It does not appear from their response that they have yet completely accomplished this recommendation.*

We agree with your response.

14 C-1 *There is no indication that VRI produces ongoing reports detailing the number of cases selected for screening versus the actual cases managed.*

VRI supplied this information to the State of Montana on a routine basis until the autumn of 1997. At that time the State benefits coordinator requested that we provide a weekly report limited to open and closed cases and discontinue sending the report on screened cases. VRI continues to tally the number of cases screened verses the number opened to case management for our own use. **Attachment D** shows a copy of the report we now provide to the State of Montana on opened and closed cases as well as our internal report which shows screening (unassigned cases) versus opened cases. We met this recommendation in 1997 and have moved to a different summary report at the request of the State of Montana.

14 (C-5d) *If approved by the State, consider limiting the use of extra-contractual benefits overrides to both pick up the patient's coinsurance responsibility and adding benefits where the plan design has a fixed limited amount (e.g. home health visits, physical therapy dollars, etc.).*

VRI communicates with the State of Montana's benefit coordinator before any waiver of a patient's coinsurance liability occurs. The State of Montana has supported our policy to consider waiving a copayment where it benefits both the patient with a financial hardship and reduces the cost to the State. VRI does try to stay within the benefit design and we supplied several cases where **no** co-payment was waived. We believe there was a typo in the last sentence of your response where you stated "VRI supplied several cases in which they have waived coinsurance responsibility."

I am hopeful we have provided sufficient additional explanation and evidence to move some of the recommendations you put in "Needs Improvement" to "Evidence of Improvement." VRI takes your audit and recommendation seriously. We appreciate your reconsideration. Please feel to contact me if you have further questions at 406/327-7273.

Sincerely,

Deslie D. Gianchetta, MBA, CRC
Executive Vice President & COO

DDG/tp
Attachments

Attachment A

(PROTOCOL – Policy on Negotiations)

I. **POLICY**

To provide appropriate, cost effective, quality health care services to the client.

II. **PROCEDURE**

1. Determine the clients needs

2. If there is a pricing agreement in place
   a. Inform the vendor of what services are required and for what duration

3. If there is NO pricing agreement
   a. Contact other care managers (CM) for previous pricing
   b. Negotiate
   c. If new negotiations are made share information with other care managers
   d. Attempt to recruit reliable, cost-effective (but non-participating) providers into the provider discount network

```
IMPCON1   3.00 .00.0          MANAGED CARE MONTANA                DATE: 08/03/98
REVIEW DATE: MM / DD / YY  CONCURRENT REVIEW SCREEN               TIME: 09:17:41
MITTELSTAEDT        VIVIAN     AGE:  51 X46546100  000032386056      002
PHYSICIAN ID:              H              FACILITY ID:              H


                     ST:    ZIP:                              ST:    ZIP:
   -    -                                        -    -      FACILITY TYPE:
DESC TREAT:
DIAG CD1:          H GROUP..:        LOS:          CONSULT ID..:
     CD2:          H ADM DT.: MMDDYY               LAST COVERED: MMDDYY
     CD3:          H ADM ST.:                      ADM LOS APPR:
PROC CD1:          H DATE1..: MMDDYY HC4:          GROUP:          LOS:
     CD2:          H DATE2..: MMDDYY HC4:
ADM CRITERIA.:               CHG STAT.:      ICM IND:    D/C TIME:    :    : 00
                                                NON-COMPL/COMP:
CONTACT......:                        SSO STAT:    NOTIFY LATE?(Y/N):
CON CRIT. H .:                ACT REV DT: MMDDYY    ACT DIS DT.......: MMDDYY
EXT LOS REQ..:      EXTENSION A/D....:              EXT LOS APPR.....:
REFERRAL.....:      CONSULT ID.......:              TOT EXT LOS......:
CON CHANGE ST:      REV COMPLETE.....:              CON REV COMPLETE.:
ADDL DOC.....:      SEND LETTER......:              DATE ENTERED.....:
                    ENTER DATA, HIT PF12 TO PROCEED      USER......:
PLEASE ENTER REVIEW DATE OR CLEAR TO RETURN TO ELIGIBILITY
```

Attachment B

```
IMPPRE1 3.00 .00.0          MANAGED CARE MONTANA                  DATE: 08/03/98
USERID: MCMVEM1          PREADMISSION REVIEW SCREEN               TIME: 09:17:26
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PHYSICIAN ID:            H              FACILITY ID:              H


                    ST:    ZIP:                              ST:    ZIP:
   -    -                                          -    -      FACILITY TYPE:

TYPE OF DETERMINATION:    FEES==>PROPOSED: 000000 R&C: 000000 APPROVED: 000000
DESC TREAT:
       CODE     GROUP  LOS
DIAG :         H
     :         H                PROC
     :         H              --DATE--    -HC4-
PROC :         H              MM DD YY
     :         H              MM DD YY
ICM IND......: N          NON-COMPL/COMP.:
ANT ADM DATE.: MM DD YY   CRITERIA... H .:          OUTPATIENT...:
REQUESTED LOS:   0        ADMISSION A/D/O:          APPROVED LOS.:   0
REFERRAL.....: N          CONSULT PHYS ID:          CHANGE STATUS:
RETRO IND....:            ACT DISCHARGE..:          ADDL DOC.....: N
SSO STAT.....:            SEND LETTER....: Y        DATE ENTERED.: 1998/08/03
```

Attachment B

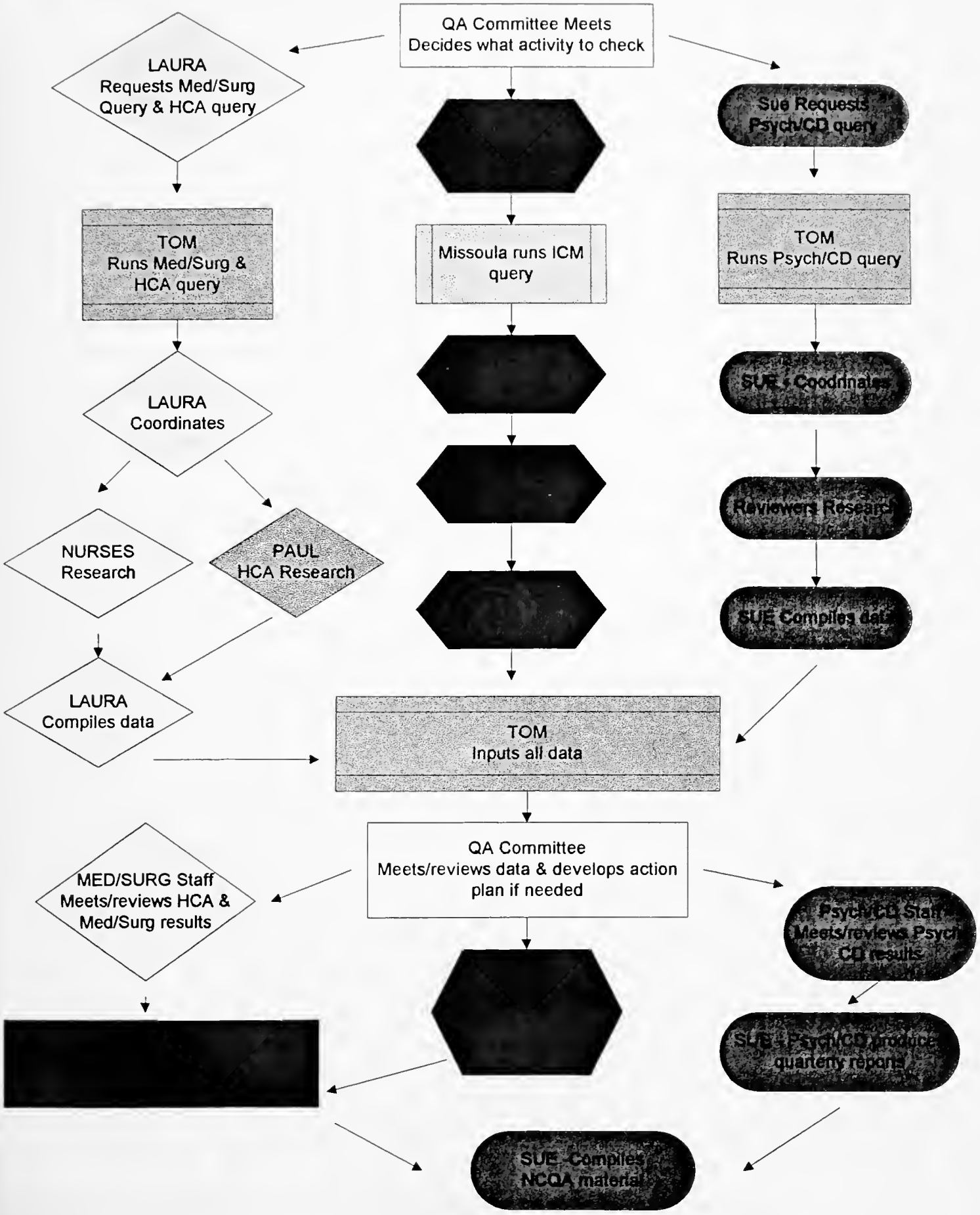
```
IMPADM1 3.00 .00.0          MANAGED CARE MONTANA                DATE: 08/03/98
USERID: MCMVBM1           ADMISSION REVIEW SCREEN               TIME: 09:18:15
MITTELSTAEDT        VIVIAN     AGE: 051 X46546100  000032386056      002
PHYSICIAN ID:            H              FACILITY ID:             H


                    ST:    ZIP:                              ST:    ZIP:
   -    -                                          -    -     FACILITY TYPE:

                         FEES==>PROPOSED: 000000 R&C: 000000 APPROVED: 000000
DESC TREAT:
      CODE     GROUP  LOS
DIAG :         H
     :         H               PROC
     :         H              --DATE--    -HC4-
PROC :         H              MM DD YY
     :         H              MM DD YY
ICM IND.....: N          NON-COMPL/COMP.:
ADM DATE.....: MM DD YY  CRITERIA... H .:          OUTPATIENT...:
REQUESTED LOS:   0       ADMISSION A/D/O:          APPROVED LOS.:   0
REFERRAL.....: N         CONSULT PHYS ID:          CHANGE STATUS:
RETRO IND....:           ACT DISCHARGE..:          ADDL DOC.....: N
SSO STAT.....:           SEND LETTER....: N        DATE ENTERED.: 1998/08/03
```

Attachment B

Attachment C



VRI A MANAGED CARE COMPANY

MANAGED CARE MONTANA

July 6, 1998

Larry Tobiason, Benefits Specialist
State of Montana
Employee Benefits Division
Mitchell Building
Helena, MT 59620

RECEIVED
JUL 07 1998
MC DEPT

OPEN CASES WEEK ENDING July 2, 1998.

Open Date	Patient	Diagnosis	Nurse Care Manager
6/30/98	D B	Thoracic-aortic aneurysm	Vanessa Hegg, RN
6/29/98	O M	Diabetic Type II	Susan Aber, RN

CLOSED CASES WEEK ENDING July 2, 1998.

Close Date	Patient	Diagnosis	Nurse Care Manager
6/29/98	J C	Respiratory abnorm	Sondra Powers, RN

Next update will be run July 13, 1998.

Sincerely,

Carol A. Fox

Carol Fox, RN, CCM
Care Management Supervisor

Table lists State of Montana opened Cases

Screened vs. Opened Cases

Date	Sub. ID	Group No.	Patient Name	Case Manger.	Diagnosis	Date Assigned.
4-28-97	1	A	JD	J Fastenau	–	4-28
4-29-97	2	B	ED	J Smith	closed heading	4-29
5-23-97	3	C	MW	S Powers	poss. saracen	4-29
4-25-97	4	D	DM	J Smith	meningiana	4-29
4-27-97	5	E	LC	J Smith	hem	4-29
4-28-97	6	F	DF	J Fastenau	Diah	4-30
4-30-97	7	G	DW	S Power	Ca Lung	5-02
4-25-97	8	H	NW	F Michels	OV Ca	5-02
4-24-97	9	I	WR	C Fox	Cervical Ca	5-02

CASE TOTALS

Cases Screened for State of Montana

Cases Screened in Whole Book of Business

Federal Employee Program

Date	Unassigned New	State of Montana	FEP	Comments
4-28-97	82	17	8	
4-29-97	92	21	10	
4-30-97	74	14	6	
5-1-97	61	11	5	
5-2-97	65	14	4	

Exhibit 8 — VRI's Addendum to Response to Auditor's Draft Report

ADDENDUM TO STATE OF MONTANA AUDIT RESPONSS

AUGUST 14, 1998

A CARE MANAGEMENT COMPANY

3011 PALMER STREET • P.O. BOX 16090 • MISSOULA, MONTANA 59808-6090
406/327-7000 • FAX 406/543-0020

August 14, 1998

Nancy Hakes, R.N., M.S.N.
The Segal Company
5080 North 40th St., Ste. 400
Phoenix, AZ 85018

RE: Addendum to State of Montana Audit Response

Dear Ms. Hakes:

As you requested we are providing some additional information to specific recommendation numbers. I am hopeful the attachments will provide you with better evidence that supports VRI's improvement in the respective areas. Please call Paul Bogumill for any further clarification of this additional information at 406/444-8347.

1. *Shift the emphasis of case management efforts from negotiating discounts on individual cases to redirection of patients toward providers where a previously negotiated discount arrangement is in place.*

Provided as Attachment A is an example of a specific pricing arrangement for a preferred provider. This type of listing is kept at case managers' desks for easy access. As you can see, once a service has been determined to be appropriate, this listing provides the specifics to assist them in quickly moving through case negotiations.

This information is indexed by geographic area and by vendor type. For areas without pricing agreements the nurse refers to a vendor agreement that is close in geographic proximity and uses the negotiated pricing as a baseline.

The use of preferred providers will be constantly growing and maturing. As stated earlier, we are working in coordination with BCBSMT to develop a statewide network for services at sub-acute and skilled levels of care. Future plans include developing/enhancing the following networks in conjunction with BCBSMT:

- Infusion Therapy
- Hospice
- Home Health
- Transportation

2. *Document vendor/physician treatment plan with VRI proposed treatment plans.*

This is an area that we continue to add emphasis for improved documentation with our staff.

3. *Develop formal and comprehensive written screening guidelines specific to the kinds of situations confronting case management services.*

In addition to our use of Milliman and Robertson, VRI develops internal protocols which provide guidelines for specific reoccurring case management services. An example is our Hospice protocol. This

is enclosed as Attachment B. This protocol was developed in response to expanded hospice benefits. Hospice prefers to use a per diem pricing arrangement (inclusive of a number of daily services) which for most members is not representative of what the member or family wants or needs. We unbundle the hospice per diem and negotiate by service fee for appropriate services. As mentioned above, we will be developing a preferred network for hospice services with BCBSMT.

5. *While this QA program addresses some of the 1996 recommendations, there is no evidence the other two recommendations for internal QA review of nurse's application of criteria and Physician Advisor decisions has been implemented.*

Provided as Attachments C are copies of our QA review process for:

1) Medical Surgical Limited Reviews (M/S Limited Rev.) Closed Cases
2) Medical Surgical Health Care Advisor 3/97 – 4/97
3) Individual Case Management (ICM), March '97 Closed Cases
4) QA Meeting Minutes for 3/11/97
5) Quality Assurance Protocol with Worksheets for Reviews

Each of the summary reviews (for Limited Reviews, Health Care Advisor, and ICM) have a narrative attached. We also enclosed our QA Meeting Minutes and QA Protocol with the worksheets which were used for the summary reviews.

14 C-1 *There is no indication that VRI produces ongoing reports detailing the number of cases selected for screening versus the actual cases managed.*

Attachment D is a document which compiles weekly information regarding screened (unassigned new) cases, open cases, and closed cases for the State of Montana for the week ending, August 7, 1998.

14 (C-5d) *If approved by the State, consider limiting the use of extra-contractual benefits overrides to both pick up the patient's coinsurance responsibility and adding benefits where the plan design has a fixed limited amount (e.g. home health visits, physical therapy dollars, etc.).*

The examples we provided you in our letter of August 6, 1998 represents cases where our case managers stayed within the benefit design and directed reimbursement toward regular benefits or benefit approval to medical review. By directing care in this manner the services would apply to the patient's regular benefits including coinsurance and deductibles. I hope this better clarifies our efforts to limit extra-contractual overrides and to stay within the benefits when the plan design has fixed amounts.

Nancy, I am hopeful this additional information will clarify some of your questions.

Sincerely,

Deslie D. Gianchetta, MBA, CRC
Executive Vice President & COO

DDG/tp
Attachments

VRI A MANAGED CARE COMPANY

MANAGED CARE MONTANA

RECEIVED
SEP 26 1997
MC DEPT

September 19, 1997

[redacted]

Dear Vendor,

We have reviewed your prices. We have revised some of the prices as follows. If you are in agreement with these prices please sign and return in the enclosed Self Addressed, Stamped Envelope.

Additional nurse visits are to be negotiated between VRI and the respective home health agency.

Therapies:

A.	*Antibiotic therapy*	
	Frequency	***Charge per day***
	Every 24 hours	[redacted]
	Every 12 hours	
	Every 8 hours	
	Every 6 hours	
	Every 4 hours	
	Cost for double antibiotic	2nd @ [redacted]
	Cost of triple antibiotic	2nd and 3rd @ [redacted]
B.	*Enteral Nutrition*	[redacted]
		[redacted]
C.	*Hydration solutions*	***Charge per day***
	1 liter per day	[redacted]
	2 liters per day	
	3 liters per day	
	4 liters per day	

ATTACHMENT A

Transwestern I, Suite 300 • 404 North 31st Street • Billings, Montana 59101 • 406-254-6263 • Fax 406-254-2565

D.	*Pain Management*	***Charge per day***
	Central	[redacted]
	Peripheral	
	Sub-Q	
	Epidural	
E.	*Chemotherapy*	***Charge per day***
	Continuous	[redacted]
	IV push/Intermittent	
F.	*Dobutamine*	***Charge per day***
		[redacted]
G.	*Continuous Heparin*	***Charge per day***
		[redacted]
H.	*Inhaled Pentamidine*	***Charge per day***
		[redacted]

I.	*Total Parenteral Nutrition*	***Charge per day***	
	Standard TPN Solution 500 ml per day including lipids 10% 2 times per week.	[redacted]	Will pay additional lipids @ [redacted]
	Standard TPN Solutions 1 liter per day including lipids 10% 2 times per week.	[redacted]	
	Standard TPN Solution 1.5 liters per day including lipids10% 2 times per week.	[redacted]	
	Standard TPN Solution 2 liters per day including lipids 10% 2 times per week.	[redacted]	
	Standard TPN Solution 2.5 liters per day including lipids 10% 2 times per week.	[redacted]	
	Standard TPN Solution 3 liters per day including lipids 10% and/or 1/500 ml 20%.	[redacted]	

J.	*Other therapies*	***Charge per day***
	Colony Stimulating Factor (G & GM-CSF) Sub-Q	[redacted]
	IV Push	
	Continuous	
K.	*Intravenous Immunoglobulins (IVIG)*	[redacted]
	Prolastin	[redacted]
	Coagulation Products	
	Human Grown Hormone (Humtrope)	[redacted] (this is monthly)

If you have any questions or concerns please contact Carlotta Hecker, Director of Case Management services at (405)254-6263.

[redacted]

Vendor Signature

September 21, 1997

Date

(PROTOCOL - Hospice Cases)

I. **POLICY**

All hospice cases will be opened to Individual Care Management (ICM) to ensure the appropriate use of the hospice benefit and to provide alternatives to inpatient hospitalization.

II. **PROCEDURE**

1. Confirm eligibility with insurer for Original Effective Date (OED), Paid to Date (PTD), primary active policy, hospice benefits, pre-existing conditions met/waived. No case will be considered if the subscriber's policy is not active.

2. Obtain verbal consent to open by client and/or family

3. Verify diagnosis and prognosis with attending physician. (To qualify for hospice, the prognosis must be six months or less.) The attending physicians H & P is helpful. A release of information is required to obtain records.

4. Contact client or family member to identify their needs. This may be done telephonically or with an on-site visit.

5. Contact the hospice agency which can be chosen by the client or family. The hospice agency will do the initial assessment and communicate his/her findings to the Care Manager. The Care Manager will then formulate a treatment plan and measurable goals.
   a. If licensed hospice agency is not available, the Care Manager may use a home care agency.

6. The Care Manager will negotiate pricing and authorize services as needed.
   a. The Care Manager negotiates fee for service unless the clients needs are extensive and a per diem rate would be more cost effective.
   b. The Care Manager will submit a contract with agreed services and pricing to subscriber, vendor and physician.
   c. Claims will be submitted to the Care Manager for review/approval.
   d. When approved for payment, the claim is submitted to appropriate claim processor at BCBS for that group.

7. The Care Manager will maintain contact with the client and family as needed. (Guidelines; never less than twice per month).

8. Total savings outcome reports (TSO's) are submitted monthly.
   a. Savings may be realized by using the monthly per diem rate verses fee for service rate.
   b. Savings may be realized by averting hospitalization.
   c. Cost savings may be determined at case closure.

ATTACHMENT B

9. When billing at death, the Care Manager needs to anticipate all costs for the closure of the case and enter the time and billing on the time tracker system no later than the day of the client's death.

10. A closing letter (close2.doc) with the Care Managers evaluation is sent to the family.

(1)

QUALITY ASSURANCE REPORT

M/S Limited Rev (2/97 closed cases/rev 4/97)

NUMBER OF CLOSED CASES REVIEWED 90

OVERALL PERCENT CORRECT 79.65

	SCREENS	ERROR TALLY	PERCENT CORRECT	SCREEN ACCURACY
A	ELIGIBILITY VERIFICATION	#	REVIEWED	0
1	Certificate number correct			
2	Cross-certificate number identified & handled correctly			
3	Group number correct			
4	Verification of eligibility/case appropriate for review			
5	Subscriber's name /demographics correct			
6	Patient's name correct			
7	Patient's date of birth correct			
B	PREADMISSION/ADMISSION	#	REVIEWED	0
1	Descriptive tx/primary dx and procedure			
2	ICD-9 diagnosis code			
3	ICD-9 procedure code			
4	Admission date correct			
5	Procedure date correct			
6	ICM indicator			
7	Requested LOS			
8	Approved LOS			
9	Referral to health care advisor as appropriate			
10	Criteria field correct for scenario			
11	Change status code correct			
12	PPO waiver			
13	Approval/denial/other			
C	INITIAL REVIEW DOCUMENTATION	#	REVIEWED	90
1	Proper heading of date, time, & user id			
2	Name of contact person & his/her department & facility			
3	Date of admission			
4	**Place of admit**	**7**	**92%**	
5	Attending physician			
6	Reviewer's name and title			
7	Initial diagnosis			
8	Initial procedure			
9	Clinical information sufficient to support appropriateness			
10	Plan of care			
11	**Special needs of patient identified for discharge**	**36**	**60%**	
12	Does documentation support criteria used?			
13	If referral indicated, was physician advisor notified?			
14	Number of days approved stated			
15	Last certified day stated/advised of further days at risk a			
16	Was information received within 24 hours of notification			
17	If information not received within 24 hours of notification			

ATTACHMENT C

	SCREENS	ERROR TALLY	PERCENT CORRECT	SCREEN ACCURACY
D	CONCURRENT SCREEN	#	REVIEWED	0
1	New or changed diagnosis code			
2	New procedure code			
3	ICM indicator updated, if appropriate			
4	Contact name			
5	Late notification			
6	Criteria field correct for scenario			
7	Extended LOS requested			
8	Extended LOS approved			
9	Referral to health care advisor as appropriate			
10	Concurrent change status code correct			
11	Letter indicator correct			
12	Discharge date correct			
13	Approval/denial			
E	CONCURRENT DOCUMENTATION #REVIEWED	#	REVIEWED	98
1	Proper heading of date, time, & user id			
2	Name of contact person & his/her department & facility			
3	Reviewer name and title			
4	New or changed diagnosis			
5	New procedure			
6	Current status & tx sufficient to support criteria used			
7	**Discharge plans**	**13**	**87%**	
8	If referral indicated, was health care advisor notified?			
9	Number of days extended			
10	Last certified day stated/advised of further days at risk a			
11	Was information received within 24 hours of LCD? (Ide			
12	If information was not received within 24 hours of LCD,			
F	FOLLOWING PROTOCOLS AS APPROPRIATE FOR CASE			
1	Retroreview			
2	Focus review			
3	Other protocol as indicated for case			
G	TYPOGRAPHICAL ERRORS			
1	0-5 errors average/page of documentation			
2	5-10 errors average/page of documentation			
3	10-15 errors average/page of documentation			
4	15+ errors average/page of documentation			

VRI A Managed Care Company

MANAGED CARE MONTANA

P.O. Box 1165 • Helena, Montana 59624-1165 • 1-800-635-5271 or 406-444-8550 (Helena) • Fax 406-442-1357

MEMORANDUM

TO: Med/surg Reviewers

FROM: Laura Harris, QA Committee

DATE: 04/01/97

RE: April QA Reviews

February Closed Cases will be reviewed using a focus review approach. The following areas which were below 90% on September's closed cases will be reviewed:

Preadm/adm -
ICD-9 coding - B2

Initial Documentation -
Place of Admit - C1d
Special needs of patient - C2e

Concurrent Screen -
New or changed diagnosis code - D1

Concurrent Documentation -
Discharge Plans - E2d

Only these areas indicated require review on the QA worksheet. All others should remain blank. Please continue to indicate the number of concurrent screens by using one concurrent worksheet per concurrent screen and the same for concurrent documentation. QA reviews are due back to me on 04/21/97. Remember to choose another case if the ones I have highlighted were reviewed exclusively by you. I would appreciate the case query sheet to be sent back with the cases you review. If you have any questions please do not hesitate to call me. My extension is 8290.

NARRATIVE SUMMARY FOR MED/SURGICAL REVIEWS
for February 1997 Closed Cases

The following summarization is a narrative description of the errors and/or comments found on the 11% of closed cases for February 1997.

# [redacted], Case #6	C2e -	No special needs for patient documented * on Doc Re: discharge an erroneous date was put in. He was admitted on the 11th, so could not have been discharged on the 10th.
# [redacted], Case #5	E2d -	No special needs noted on concurrent screen but discharge was asked about.
# [redacted], Case #4	C2e -	No special needs identified. It was noted that both parents work.
# [redacted], Case #3	C2e -	No special needs identified although DOC does state "patient has very supportive spouse at home" which is important.
# [redacted], Case #2	C2e -	No special needs identified.
# [redacted], Case #7	C2e -	No special needs identified.
# [redacted], Case #8	C2e - E2d -	No special needs identified. No discharge plan.
# [redacted], Case #9	C2e -	No specific discharge needs documented.
# [redacted], Case #10	C2e -	Reviewer asked about discharge plans but no specifics noted.
# [redacted], Case #1	C2e -	No specific needs re: discharge noted.
# [redacted], Case #4	C2e - E2d -	No special needs identified. No discharged plans - Limited Review
# [redacted], Case #2	C1d - E2d - C2e -	No facility identified in DOC. No discharge needs in DOC. No special needs - Limited Review
# [redacted], Case #1	C1d - C2e - E1d -	No facility identified in DOC. No special needs identified. No discharge plans in DOC.
# [redacted], Case #4	C1d - C2e -	Facility not identified in DOC No special needs for discharge.
# [redacted], Case #1	C2e -	No special needs identified.

# [redacted], Case #1	C2e -	No needs identified.
	E2d -	No discharge plans in DOC.
# [redacted], Case #1	E2d -	No discharge plans in DOC.
# [redacted], Case #1	C2e -	No special needs identified.
	E2d -	No discharge plans in DOC.
# [redacted], Case #3	C2e -	No special needs identified on admit
# [redacted], Case #1	C2e -	No special needs identified on admit in DOC.
	E2d -	No discharge plans in DOC.
# [redacted], Case #3	E2d -	No discharge plans - Limited Review.
# [redacted], Case #1	C2e-	No special needs identified.
# [redacted], Case #3	C2e -	No special needs identified.
# [redacted], Case #6	C2e -	No special needs identified.
# [redacted], Case #1	E2d -	No discharge plans noted.
# [redacted], Case #1	C2e -	No special needs, this was certed in advance.
# [redacted], Case #2	C2e -	Marked as "no" but no comments made.
# [redacted], Case #2	C2e -	Marked as "no" but no comments made.
# [redacted], Case #2	C2e -	Nice review on this newborn. Info was left on reviewers voice mail. No discharge planning needs but I don't think reviewer can help it in this situation (not counted as an error).
# [redacted], Case #7	C2e -	No special needs identified.
# [redacted], Case #6	E2d -	No discharge plans noted on lst concurrent review.
# [redacted], Case #1	C2e -	No special needs identified.
# [redacted], Case #23	C1d -	On initial documentation to advice of admit, place of admit not documented. Initial clinical does have place of admit.
# [redacted], Case #3	C2e -	No discharge needs identified/documented.
	E2d -	No discharge plans documented except for highlighted area by Julie that this admit for chemo is prep for stem cell transplant.
# [redacted], Case #1	C1d -	No place of admit listed in DOC.

# [redacted], Case #1	C1d -	No place of admit listed in DOC.
# 8 [redacted], Case #1	C2e -	Special needs of patient not identified.
# 0 [redacted], Case #5	C2e -	Special needs of patient not identified in initial review.
# [redacted], Case #3	C1d -	Place of admit not mentioned in initial DOC.
	C2e-	Special needs of discharge not addressed.
	2-11-97 CSR	Second update
	E2d -	No discharge plans addressed.
# [redacted], Case #2	C2e -	No special needs for discharge addressed.
# 0 [redacted], Case #1	C2e -	No special needs identified for this precertification.
# [redacted], Case #3	C2e -	No special needs identified until further DOC entries.
# 0 [redacted] Case #1	C2e -	No discharge plans.
# 5 [redacted], Case #1	C2e -	Special needs not addressed.
# 9 [redacted], Case #2	C2e-	Special needs not identified until case management entry.
# 0 [redacted], Case #1	C2e -	Special needs not addressed - Limited Review

QUALITY ASSURANCE REPORT
MED/SURG HEALTH CARE ADVISOR:3/97-4/97

NUMBER OF CASES REVIEWED 11

OVERALL PERCENT CORRECT 83%

		ERROR TALLY #	PERCENT CORRECT REVIEWED	SCREEN ACCURACY 11
1	Existing documentation reviewed	1	91%	
2	Additional information obtained	3	73%	
3	Phone conversation with attending physician attempted	3	73%	
4	Criteria for approval or denial numbered & brief descrip.	3	73%	
5	Date approval or denial effective & # of days involved	0	100%	
6	Date for next decision documented (if needed)	0	100%	
7	Information needed at time of next decision documented	1	91%	
8	Suggestions given to attending physician	1	91%	
9	Case management referral (if appropriate)	1	91%	
				83%

NARRATIVE SUMMARY FOR HEALTH CARE ADVISOR QA
MARCH-APRIL 1997 CLOSED CASES

100% of the closed cases were reviewed for the period of March through April 1997. Following are the comments made in regards to the errors found:

#[redacted], Case #1:	MD reviewed present information and felt criteria was there.
#[redacted], Case #1:	No follow-up with case.
#[redacted], Case #1:	HCA did not document on case - review I/A information and made decision. Medical override.
#[redacted], Case #3:	This case was a work comp case - closed review process.
#[redacted], Case #6:	No peer review - medical override for pre-op day.

QUALITY ASSURANCE REPORT

ICM: March 1997 Closed Cases

NUMBER OF CASES REVIEWED 40

OVERALL PERCENT CORRECT 82%

		ERROR TALLY #	PERCENT CORRECT REVIEWED	SCREEN ACCURACY 40
1	Was case opened w/in 2 working days of initial patient co	2	95%	
2	Were benefits, PTD, & OED verified by customer service	5	88%	
3	Was initial contract sent out w/in 2 working days of the co	8	80%	
4	Was contract renewed every 30 days	2	95%	
5	Was contact made w/patient , family, physician or caregiv	3	93%	
6	Were verbal or written reports received from vendors q 1	1	98%	
7	Were claims reviewed & sent for payment w/in 10 days o	11	73%	
8	Was termination letter sent?	12	70%	
9	Were goals documented at the beginning of the case?	6	85%	
				82%

ICM QA Monthly Report

July 15, 1997

40 of 46 closed case for the month of March 1997 were reviewed using the QA tool developed at the ICM meetings

The desired outcome is 90% in all areas.

The actual outcome was 82% overall, an improvement from 66% at last review.

The tool was reevaluated: #7 wording was added to clarify FEP and MUS claims review. It was discussed that because these groups require contracts to be signed by the subscriber before claims can be submitted for payment, claim processing is oftentimes delayed until the signed contract is received by the Case Manager.

It was suggested that the criteria met at this review, not be reviewed again for six months and new criteria be developed. This will be discussed further at the next Case Managers meeting.

The case closure evaluation letter and tool was discussed. Liz will develop another questionnaire, using guidelines from the Managed Care Certification Review questionnaire and distribute to the Case Managers for consideration.

Carlotta has developed a tool for reviewing cases for audits that she will also be using for individual Case Manager evaluations. This list was distributed to all the Case Managers. Criteria in this tool are:
VRI referral source
Goals in 1 week
Benefits checked
Assess treatment plan
Biweekly contract if appropriate
Was CM in control of case
Positive outcome
Goal accomplished
Cost savings verified

Further discussions with Marcia Nettleton, BCBS claims department, are needed for contract clarification. It was also identified that discussions need to be held with Vicky Rydquist and Veronica Schaefer of FEP claims.

The TSO new format was discussed and questions answered. Further refinements might be needed but all Case Managers are to use the new format beginning this month for June'97.

The general QA meeting of June 19, 1997 was reviewed.

QA Meeting Minutes

March 11, 1997

Participants: Paul Bogumill, Laura Harris, Vivian Mittelstaedt Sue Webking, Liz Wheeler	Actual Starting Time: 10:00 am Actual Ending Time: 11:30 am Person Taking Minutes: J'Dawn Elliott

ISSUE	*CONCLUSION/RECOMMENDATION*	*ACTION TAKEN*	*FOLLOW UP/DATE*
CS Survey	Determined groups/individuals to be included in mailing list. Paul sent freemail asking for survey suggestions to be submitted to Donna. Sue Webking gave Paul a copy of Dave Johnson's customer service survey (behavioral health services) which we can get ideas from.	At the next QA mtg we will look at suggestions and examples submitted and try to formulate our own cs survey.	April 15, 1997 - next QA Mtg
Newsletter	The 1st newsletter will include Intro (Paul), staff/drs/sites (Liz), and NCQA update (Sue). Judy Jones may be able to format newsletter . Our next newsletter will include CS survey.	Paul asked that the articles be ready for co-committee members to look over w/in the next 2 weeks if possible.	If possible have your article ready sometime in the week of March 24.
NCQA	There was discussion on the importance of NCQA certification. VRI's overall structure meets criteria, while certain departments do not relate to criteria. MCM med/surg is not concerned w/ URAC because companies we are bidding for contracts w/ are not requiring URAC certification. NCQA pushes all departments to set in-house standards and set up QA processes.	Med/surg will continue to follow URAC guidelines even though we are not paying for their certification.	
Med/Surg QA Reviews	Laura will be distributing the closed case list for February. Rn's will do focused reviews. Each rn will have 10 cases.		
HCA	At quarterly HCA meeting it was determined that clinical information should not be reviewed by peers until procedural problems are corrected.	Full reviews focusing on procedural inconsistencies will be continued. Paul will review March closed cases in April.	
ICM	HCAs performed audit on ICM cases. They looked at cost savings and clinical. ICM nurses felt that while there was no practical insight gained. However, the mechanism for review is in place. The HCA had access to the computer files not the paper files where cost savings are reported.	March closed cases will be reviewed in April.	

ISSUE	*CONCLUSION/RECOMMENDATION*	*ACTION TAKEN*	*FOLLOW UP/DATE*
	After the January reviews on December's closed cases, the QA tool has brought up several topics for discussion (checking eligibility, timeliness of contract mailing, termination letters, filing of claims).		
ICD-9 Coding	Joanne at BCBS is creating a user-friendly list for ICD-9 codes. Only if we go w/ MNR or some other criteria system will we have to get "coding specific".		

QUALITY ASSURANCE - (PROTOCOL 30)

I. POLICY

Managed Care Montana (MCM) will monitor team and individual performance to ensure compliance with program protocols and philosophy, as well as NCQA and Utilization Review Accreditation Commission (URAC) Standards. The Quality Assurance (QA) Program is to include the following staff members: Medical/Surgical Nurse Reviewers, Program Manger, Psychiatric/Chemical Dependency Nurse Reviewers, Health Care Advisor, & ICM Case Managers. Inconsistency in following program protocols reduces program integrity and increases program risk. Team performance also indicates the general level of understanding of program protocols and may reflect areas of need for training, orientation, and continuing reviewer education. QA data is located with the QA Coordinator.

II. DEFINITIONS

A. Quality Assurance Program: Also known as a Quality Management Program, is a structured program which, at a minimum, monitors and evaluates the quality and effectiveness of MCM policies, processes and practices. It provides management intervention, as needed, to support compliance with the National Utilization Review Standards and NCQA.

B. Staff Management Program: A structured mechanism which at a minimum credentials, orients, trains, monitors, supervises and evaluates the qualifications and performance of clinical staff, non-clinical staff, and consultants involved at all levels of review activity.

III. PROCEDURE

A. TEAM QA: QA will be done on an every other month basis for the following teams:

Med/Surg	5% closed cases (Long Form) 20% closed cases (Short Form)
Psych/CD	10% closed cases
Health Care Advisor	100% closed cases
ICM	100% closed cases

1. Closed cases from the previous month will be randomly pulled for QA review. The percentages shown above are a minimum, most QA reviews will encompass a much higher percentage. These cases are gathered per data based program after the 5th of the month following the month to be reviewed.

2. Refer to the attached flowsheet for QA process (Attachment A). QA worksheets used are also attached for each team (Attachment B -F as listed below):

Attachment B	QA Worksheet - Long Form
Attachment C	QA Worksheet - Short Form
Attachment D	QA Worksheet - Psych/CD
Attachment E	Health Care Advisor QA Review Form
Attachment F	ICM QA Review Form

3. The reviewed cases will be documented on the appropriate tool and returned to the QA Coordinator within three weeks time.

4. Scores will be tallied by the QA Coordinator and entered on a Lotus worksheet by IS Support to calculate a score which is the error percentage subtracted from 100%.

5. Any score below 90% will be analyzed to determine if the errors are random or consistent, and will be collected as examples for training and staff management programs. The report will be finalized within a week's time, and then distributed to all MCM offices and posted in central areas.

B. INDIVIDUAL QA: Quality Review is done three months from date of hire, six months from date of hire, and then yearly on anniversary date of hire.

1. Cases are pulled randomly from a closed case report gathered from a data base program. The long form is routinely used for new reviewers and the short form is used for experienced reviewers. This practice is at the discretion of the MCM Supervisor and/or the Program Manager.

2. QA Coordinator or designee will perform QA reviews.

3. Scores are loaded on Lotus Worksheet, then calculated to get a score which is the error percentage subtracted from 100%.

4. The report for the individual being reviewed is then given to the appropriate supervisor and scores are discussed with the reviewer.

5. Any score below 90% is analyzed to determine if errors are random or consistent, and are collected to be used in the training process.

C. SPECIAL NOTE: ICM has developed ICM Quality Assurance Protocol. Please refer to ICM Supervisor for current protocol.

QUALITY ASSURANCE CASE WORKSHEET

Certification Number _____ Due Date _____

Case Number _____ Med/Surg _____

	SCREEN	YES	NO	N/A
A.	**ELIGIBILITY VERIFICATION**			
1.	Certificate number correct			
2.	Cross-certificate number identified and handled correctly			
3.	Group number correct			
4.	Verification of eligibility / case appropriate for review			
5.	Subscriber's name / demographics correct			
6.	Patient's name correct			
7.	Patient's date of birth correct			
B.	**PREADMISSION / ADMISSION SCREEN**			
1.	Descriptive treatment -- primary diagnosis and procedure			
2.	ICD-9 diagnosis code			
3.	ICD-9 procedure code			
4.	Admission date correct			
5.	Procedure date correct			
6.	ICM indicator			
7.	Requested LOS			
8.	Approved LOS			
9.	Referral to health care advisor as appropriate			
10.	Criteria field correct for scenario			
11.	Change status code correct			
12.	PPO waiver			
13.	Approval / denial / other			

	INITIAL REVIEW	YES	NO	N/A
C.	DOCUMENTATION SCREEN			
1.	Basic Information			
a.	Proper heading of date, time, and user ID			
b.	Name of contact person and his / her department and facility			
c.	Date of admission			
d.	Place of admit			
e.	Attending physician			
f.	Reviewer's name and title			
2.	Initial review documentation			
a.	Initial diagnosis			
b.	Initial procedure			
c.	Clinical information sufficient to support appropriateness of setting			
d.	Plan of care			
e.	Special needs of patient identified for discharge			
f.	Does documentation support criteria used?			
g.	If referral was indicated, was health care advisor notified?			
h.	Number of days approved stated (Med/Surg)			
i.	Last certified day stated / advised of further days at risk as appropriate			
j.	Was information received within 24 hours of notification of admit? (Identify noncompliant facility / provider.)			
k.	If information was not received within 24 hours of notification of admit, was retroreview initiated?			

CONCURRENT REVIEW (Use one concurrent form for each CSR)		YES	NO	N/A
D. CONCURRENT SCREEN DATE				
1.	New or changed diagnosis code			
2.	New procedure code			
3.	ICM indicator updated, if appropriate (Med / Surg)			
4.	Contact name			
5.	Late notification			
6.	Criteria field correct for scenario			
7.	Extended LOS requested			
8.	Extended LOS approved			
9.	Referral to health care advisor as appropriate			
10.	Concurrent change status code correct			
11.	Letter indicator correct			
12.	Discharge date correct			
13.	Approval / denial			
E. DOCUMENTATION SCREEN CONCURRENT				
1.	Basic information			
a.	Proper heading of date, time, and user ID			
b.	Name of contact person and department			
c.	Reviewer name and title			
2.	Concurrent review documentation			
a.	New or changed diagnosis			
b.	New procedure			
c.	Current status and treatment sufficient to support criteria used			
d.	Discharge plans			
e.	If referral was indicated, was health care advisor notified?			
f.	Number of days extended (Med / Surg)			
g.	Last certified day stated			
h.	Was information received within 24 hours of LCD? (Identify noncompliant facility / provider.)			
i.	If information was not received within 24 hours of LCD, was retroreview initiated?			

PROTOCOL/TYPOGRAPHICAL ERRORS		YES	NO	N/A
F. FOLLOWING PROTOCOLS AS APPROPRIATE FOR CASE				
1.	Retroreview			
2.	Focus review			
3.	Other protocol as indicated for case			
G. TYPOGRAPHICAL ERRORS (Total number of errors ÷ total number of pages = average errors per page)				
1.	0 to 5			
2.	5 to 10			
3.	10 to 15			
4.	15 +			

COMMENTS: All "NO" entries must be explained. Indicate number & heading.

QA REVIEWER SIGNATURE ______________________ DATE __________

QAWRKSHT5/08961425

HEALTH CARE ADVISOR
QUALITY ASSURANCE REVIEW FORM

Certification Number _____ Due Date _____
Case Number _____ HCA _____

1) Existing documentation reviewed:	YES	NO	N/A
2) Additional information obtained:	YES	NO	N/A
3) Phone conversation with attending physician attempted:	YES	NO	N/A
4) Criteria for approval or denial numbered and brief description given:	YES	NO	N/A
5) Date approval or denial effective and number of days involved documented:	YES	NO	N/A
6) Date for next decision documented (if needed):	YES	NO	N/A
7) Information needed at time of next decision documented:	YES	NO	N/A
8) Suggestions given to attending physician:	YES	NO	N/A
9) Case management referral (if appropriate):	YES	NO	N/A

Summarize the "NO" entries in the comment section below. Indicate number and heading.

_____

_____

_____

_____

_____

_____

Was this information discussed with the HCA? YES NO

MCM Staff Date: _____ Initials: _____
HCA Date: _____ Initials: _____

Is this the second notice of the same infraction: YES NO

Individual Care Management
Quality Assurance Review Form

Certificate No._____ Date_____
Case Manager_____

1) Was case opened within two working days of initial patient contact	Yes	No	N/A
2) Were benefits, PTD and OED verified by Customer Service	Yes	No	N/A
3) Were benefits verified monthly for any changes	Yes	No	N/A
4) Were goals documented at the beginning of the case	Yes	No	N/A
5) Were the goals measurable	Yes	No	N/A
6)Was the initial contract sent out within two working days of the cost negotiation	Yes	No	N/A
7) Was the contract renewed every 30 days	Yes	No	N/A
8) Was contact made with the patient or family 3-5 times the first 2 weeks to assess intervention	Yes	No	N/A
9)Was contact made with the patient, family, physician or care giver every 15-30 days	Yes	No	N/A
10) Were verbal or written reports received from vendors every 15-30 days	Yes	No	N/A
11) Were claims reviewed and sent for payment within 10 days of receipt (see below)	Yes	No	N/A
12) Was a termination letter sent	Yes	No	N/A
13) Is there a case summary addressing goals, intervention and cost savings	Yes	No	N/A

Summarize the "No" and the "N/A" entries in the comment section below. Indicate the number.

_____
_____
_____
_____
_____

FEP and MUS contracts must be signed and returned by the subscriber before claims can be processed.

Revised 0298

MANAGED CARE MONTANA
PROTOCOL REVIEW AND APPROVAL PAGE

PROTOCOL 30
QUALITY ASSURANCE
May 1998

Laura Harris RN — 6-22-98
Assignee

Karen Buffington, RN — June 5, '98.
Committee Member

Jaime Hagmeier RN — 6-24-98
Committee Member

Kathleen Hanson — June 22, 98
Committee Member

Dates Reviewed: _____

_____

_____

_____

Paul Bogumill — 6/22/98
Program Manager MCM/VRI — Approval Date

August 10, 1998

John Patrick
State of Montana
Employee Benefits Division
Mitchell Building
Helena, MT 59620

TOTAL STATE OF MONTANA SCREENED CASES WEEK ENDING August 7, 1998.
64

OPEN CASES WEEK ENDING August 7, 1998.

Open Date	Patient	Diagnosis	Nurse Care Manager
8/6/98	N N	Sleep apnea	Elizabeth Wheeler, RN
8/7/98	A W	Normal pregnancy	Jenni Hughes, RN
8/6/98	K H	High risk pregnancy	Jenni Hughes, RN
8/4/98	J C	Pseudomonas septicemia	Jean Fastenau, RN

CLOSED CASES WEEK ENDING August 7, 1998

Close Date	Patient	Diagnosis	Nurse Care Manager
8/4/98	D G	Normal delivery	Diane Figge, RN

The next update will be run August 17, 1998. Feel free to call me if you have any questions.

Sincerely,

Carol Fox, RN, CCM
Care Management Supervisor

ATTACHMENT D

SECTION VIII - STATE ADMINISTRATION RESPONSE

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION
MARC RACICOT, GOVERNOR
MITCHELL BUILDING, ROOM 130
PO BOX 200127
STATE OF MONTANA
(406) 444-3871
HELENA, MONTANA 59620-0127

August 25, 1998

Ms. Carol S. Hoel
The Segal Company
5080 North 40th Street
Suite 400
Phoenix, Arizona
85018

Dear Carol:

I have received your audit report on administration of the State Employee Benefit Plan, as well as the follow-up review of 1996 audit recommendations for case management services, and provide the following responses to your recommendations and findings.

RECOMMENDATION 1: That BCBSMt confirm State Plan agreement with its policy of applying one deductible and/or coinsurance when charges for an inpatient confinement span two benefit periods.

RESPONSE: We concur with this recommendation and will review this policy with BCBSMt.

RECOMMENDATION 2 : That a refund request be issued for identified overpayments.

RESPONSE: We generally concur with this recommendation and BCBSMt's response that they will discuss the possibility of refunds with the plans. Given, the small dollar amount of overpayment identified for the State Plan, we are more concerned about safeguards against similar overpayments.

RECOMMENDATION 3: That BCBSMt should confirm Medicare's current position on claims for accurate coordination of benefits and that potential custodial services should be reviewed for eligibility fro coverage under the Plan's definition of eligible home health expenses.

RESPONSE: N/A This recommendation was in reference to a specific University System case, although we will review any implications for the State Plan.

RECOMMENDATION 4 : That BCBSMt implement a system edit to suspend audiology charges on patients under age two for medical review and/or investigation prior to denial.

RESPONSE: We generally concur with the concept of assuring that exclusions are applied appropriately. We will review the details of this situation with BCBSMt to determine if the recommended edit is the best way to accomplish that.

RECOMMENDATION 5 : That BCBSMt implement a system accumulator or edit that will suspend all related transplant claims which exceed the global allowance negotiated through BCBS's national transplant network.

RESPONSE: BCBSMt's response indicates that this system accumulator/edit is in place, and that the problem was clerk error which appears to be below industry standards.

RECOMMENDATION 6 : That BCBSMt advise the Legislative Auditor of any change in procedures resulting from this review as well as resolution of the payment errors addressed in the report.

RESPONSE: We concur with this recommendation

FINDINGS OF THE FOLLOW-UP REVIEW OF 1996 AUDIT RECOMMENDATIONS FOR CASE MANAGEMENT :

RESPONSE: We concur that VRI has made substantial progress in implementing prior audit recommendations and that continued improvement toward meeting recommendations 1,2,3, and 11 is desirable.

We appreciate the clarity of your audit report and the opportunity to respond.

Sincerely,

Joyce Brown
Chief, Employee Benefits

SECTION IX - UNIVERSITY RESPONSE

MONTANA UNIVERSITY SYSTEM
OFFICE OF COMMISSIONER OF HIGHER EDUCATION

2500 BROADWAY ◦ PO BOX 203101 ◦ HELENA, MONTANA 59620-3101 ◦ (406)444-6570 ◦ FAX (406)444-1469

August 27, 1998

Ms. Carol S. Hoel
The Segal Company
5080 North 40th Street
Suite 400
Phoenix, Arizona 85018

Dear Ms Hoel

Thank you for the opportunity to respond to your audit of the Montana University System employee group insurance plan as administered by Blue Cross Blue Shield of Montana.

Recommendation # 1: That BCBSMT confirm University System concurrence with its policy of applying one deductible and or coinsurance when charges for an inpatient confinement spans two benefit periods.

RESPONSE: The University System concurs with this recommendation and will review this policy.

Recommendation # 2: Refund requests should be issued for identified overpayments.

RESPONSE: The University System concurs with this recommendation and will discuss the possibility of refunds with BCBSMT.

Recommendation # 3: BCBSMT should confirm Medicare's current position for accurate coordination of benefits; potential custodial services should be reviewed for eligible coverage under the Plan's definition of eligible home health care expenses. Discussions should be held with the University to determine appropriate recovery action.

RESPONSE: The University System concurs with this recommendation and will review the case and discuss appropriate action with BCBSMT.

Recommendation # 4: We recommend BCBSMT implement a system edit to suspend audiology charges on patients under age two for medical review and/or investigation prior to denial.

RESPONSE: The University System concurs with this recommendation and will discuss BCBSMT's procedure change with BCBSMT.

Recommendation #5: BCBSMT should implement a system accumulator or edit that will suspend all related claims under the transplant network global allowance for verification of the benefit payment.

RESPONSE: While the University System concurs, it appears that BCBSMT has the recommended edit in place.

Recommendation #6: BCBSMT should advise the Legislative Auditor and designated representative for the Montana University System of any changes in procedures resulting from this review as well as resolution of the payment errors addressed in this report.

RESPONSE: The University System concurs.

Sincerely,

Glen D. Leavitt
Interim Director of Benefits